

10992 CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Mr. Joseph Henry Albers</u>		4. DATE OF DEATH <u>November 30th 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1874</u>
		9. AGE (In years last birthday) <u>82 yrs</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Genl Hospt</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
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13. FATHER'S NAME <u>Henry Albers</u>	14. MOTHER'S MAIDEN NAME <u>Elizabeth Bauer</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs. Gertrude M. Albers, Jarrettsville Md</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Left ventricular heart failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic heart disease</u> DUE TO (c) <u>12 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 w b</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>APRIL 13, 1956</u> to <u>Nov. 30, 1956</u> , that I last saw the deceased alive on <u>Nov. 24, 1956</u> , and that death occurred at <u>5:28 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Charles A. Neff</u> M.D. <u>STREET, MD</u>	DATE SIGNED <u>Nov. 30, 1956</u>
PHYSICIAN'S NAME (Type) <u>CHARLES A. NEFF M.D.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/3/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>DEC 3 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Ely Grouchy</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

DEC 3 1955

RECEIVED

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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10993 CERTIFICATE OF DEATH

10965

Reg. Dist. No. 45

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u>	STATE <u>MARYLAND</u>	STATE <u>MD</u>	COUNTY <u>BALTIMORE</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	LENGTH OF STAY (in this place) <u>3 YEARS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>804 MYRTH AVE</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>LOUIS</u> (Middle) <u>C.</u> (Last) <u>AMICONE</u>		(Month) <u>11</u> (Day) <u>23</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>7/2/1892</u>
		9. AGE last birthday <u>64</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENAMELER STANDARD RADIOS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>10</u>	
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MICHAEL AMICONE</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>M. G. AMICONE 804 MYRTH AVE</u>	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>420.0 Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic heart</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>disease.</u>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. HOW DID INJURY OCCUR?		21f. HOW DID INJURY OCCUR?	
21g. HOW DID INJURY OCCUR?		21h. HOW DID INJURY OCCUR?	
21i. HOW DID INJURY OCCUR?		21j. HOW DID INJURY OCCUR?	
21k. HOW DID INJURY OCCUR?		21l. HOW DID INJURY OCCUR?	
21m. HOW DID INJURY OCCUR?		21n. HOW DID INJURY OCCUR?	
21o. HOW DID INJURY OCCUR?		21p. HOW DID INJURY OCCUR?	
21q. HOW DID INJURY OCCUR?		21r. HOW DID INJURY OCCUR?	
21s. HOW DID INJURY OCCUR?		21t. HOW DID INJURY OCCUR?	
21u. HOW DID INJURY OCCUR?		21v. HOW DID INJURY OCCUR?	
21w. HOW DID INJURY OCCUR?		21x. HOW DID INJURY OCCUR?	
21y. HOW DID INJURY OCCUR?		21z. HOW DID INJURY OCCUR?	
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21ac. HOW DID INJURY OCCUR?		21ad. HOW DID INJURY OCCUR?	
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21bw. HOW DID INJURY OCCUR?		21bx. HOW DID INJURY OCCUR?	
21by. HOW DID INJURY OCCUR?		21bz. HOW DID INJURY OCCUR?	
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21jy. HOW DID INJURY OCCUR?		21jz. HOW DID INJURY OCCUR?	
21ka. HOW DID INJURY OCCUR?		21kb. HOW DID INJURY OCCUR?	
21kc. HOW DID INJURY OCCUR?		21kd. HOW DID INJURY OCCUR?	
21ke. HOW DID INJURY OCCUR?		21kf. HOW DID INJURY OCCUR?	
21kg. HOW DID INJURY OCCUR?		21kh. HOW DID INJURY OCCUR?	
21ki. HOW DID INJURY OCCUR?		21kj. HOW DID INJURY OCCUR?	
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21ky. HOW DID INJURY OCCUR?		21kz. HOW DID INJURY OCCUR?	
21la. HOW DID INJURY OCCUR?		21lb. HOW DID INJURY OCCUR?	
21lc. HOW DID INJURY OCCUR?		21ld. HOW DID INJURY OCCUR?	
21le. HOW DID INJURY OCCUR?		21lf. HOW DID INJURY OCCUR?	
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21lk. HOW DID INJURY OCCUR?		21ll. HOW DID INJURY OCCUR?	
21lm. HOW DID INJURY OCCUR?		21ln. HOW DID INJURY OCCUR?	
21lo. HOW DID INJURY OCCUR?		21lp. HOW DID INJURY OCCUR?	
21lq. HOW DID INJURY OCCUR?		21lr. HOW DID INJURY OCCUR?	
21ls. HOW DID INJURY OCCUR?		21lt. HOW DID INJURY OCCUR?	
21lu. HOW DID INJURY OCCUR?		21lv. HOW DID INJURY OCCUR?	
21lw. HOW DID INJURY OCCUR?		21lx. HOW DID INJURY OCCUR?	
21ly. HOW DID INJURY OCCUR?		21lz. HOW DID INJURY OCCUR?	
21ma. HOW DID INJURY OCCUR?		21mb. HOW DID INJURY OCCUR?	
21mc. HOW DID INJURY OCCUR?		21md. HOW DID INJURY OCCUR?	
21me. HOW DID INJURY OCCUR?		21mf. HOW DID INJURY OCCUR?	
21mg. HOW DID INJURY OCCUR?		21mh. HOW DID INJURY OCCUR?	
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21mm. HOW DID INJURY OCCUR?		21mn. HOW DID INJURY OCCUR?	
21mo. HOW DID INJURY OCCUR?		21mp. HOW DID INJURY OCCUR?	
21mq. HOW DID INJURY OCCUR?		21mr. HOW DID INJURY OCCUR?	
21ms. HOW DID INJURY OCCUR?		21mt. HOW DID INJURY OCCUR?	
21mu. HOW DID INJURY OCCUR?		21mv. HOW DID INJURY OCCUR?	
21mw. HOW DID INJURY OCCUR?		21mx. HOW DID INJURY OCCUR?	
21my. HOW DID INJURY OCCUR?		21mz. HOW DID INJURY OCCUR?	
21na. HOW DID INJURY OCCUR?		21nb. HOW DID INJURY OCCUR?	
21nc. HOW DID INJURY OCCUR?		21nd. HOW DID INJURY OCCUR?	
21ne. HOW DID INJURY OCCUR?		21nf. HOW DID INJURY OCCUR?	
21ng. HOW DID INJURY OCCUR?		21nh. HOW DID INJURY OCCUR?	
21ni. HOW DID INJURY OCCUR?		21nj. HOW DID INJURY OCCUR?	
21nk. HOW DID INJURY OCCUR?		21nl. HOW DID INJURY OCCUR?	
21nm. HOW DID INJURY OCCUR?		21nn. HOW DID INJURY OCCUR?	
21no. HOW DID INJURY OCCUR?		21np. HOW DID INJURY OCCUR?	
21nq. HOW DID INJURY OCCUR?		21nr. HOW DID INJURY OCCUR?	
21ns. HOW DID INJURY OCCUR?		21nt. HOW DID INJURY OCCUR?	
21nu. HOW DID INJURY OCCUR?		21nv. HOW DID INJURY OCCUR?	
21nw. HOW DID INJURY OCCUR?		21nx. HOW DID INJURY OCCUR?	
21ny. HOW DID INJURY OCCUR?		21nz. HOW DID INJURY OCCUR?	
21oa. HOW DID INJURY OCCUR?		21ob. HOW DID INJURY OCCUR?	
21oc. HOW DID INJURY OCCUR?		21od. HOW DID INJURY OCCUR?	
21oe. HOW DID INJURY OCCUR?		21of. HOW DID INJURY OCCUR?	
21og. HOW DID INJURY OCCUR?		21oh. HOW DID INJURY OCCUR?	
21oi. HOW DID INJURY OCCUR?		21oj. HOW DID INJURY OCCUR?	
21ok. HOW DID INJURY OCCUR?		21ol. HOW DID INJURY OCCUR?	
21om. HOW DID INJURY OCCUR?		21on. HOW DID INJURY OCCUR?	
21oo. HOW DID INJURY OCCUR?		21op. HOW DID INJURY OCCUR?	
21oq. HOW DID INJURY OCCUR?		21or. HOW DID INJURY OCCUR?	
21os. HOW DID INJURY OCCUR?		21ot. HOW DID INJURY OCCUR?	
21ou. HOW DID INJURY OCCUR?		21ov. HOW DID INJURY OCCUR?	
21ow. HOW DID INJURY OCCUR?		21ox. HOW DID INJURY OCCUR?	
21oy. HOW DID INJURY OCCUR?		21oz. HOW DID INJURY OCCUR?	
21pa. HOW DID INJURY OCCUR?		21pb. HOW DID INJURY OCCUR?	
21pc. HOW DID INJURY OCCUR?		21pd. HOW DID INJURY OCCUR?	
21pe. HOW DID INJURY OCCUR?		21pf. HOW DID INJURY OCCUR?	
21pg. HOW DID INJURY OCCUR?		21ph. HOW DID INJURY OCCUR?	
21pi. HOW DID INJURY OCCUR?		21pj. HOW DID INJURY OCCUR?	
21pk. HOW DID INJURY OCCUR?		21pl. HOW DID INJURY OCCUR?	
21pm. HOW DID INJURY OCCUR?		21pn. HOW DID INJURY OCCUR?	
21po. HOW DID INJURY OCCUR?		21pp. HOW DID INJURY OCCUR?	
21pq. HOW DID INJURY OCCUR?		21pr. HOW DID INJURY OCCUR?	
21ps. HOW DID INJURY OCCUR?		21pt. HOW DID INJURY OCCUR?	
21pu. HOW DID INJURY OCCUR?		21pv. HOW DID INJURY OCCUR?	
21pw. HOW DID INJURY OCCUR?		21px. HOW DID INJURY OCCUR?	
21py. HOW DID INJURY OCCUR?		21pz. HOW DID INJURY OCCUR?	
21qa. HOW DID INJURY OCCUR?		21qb. HOW DID INJURY OCCUR?	
21qc. HOW DID INJURY OCCUR?		21qd. HOW DID INJURY OCCUR?	
21qe. HOW DID INJURY OCCUR?		21qf. HOW DID INJURY OCCUR?	
21qg. HOW DID INJURY OCCUR?		21qh. HOW DID INJURY OCCUR?	
21qi. HOW DID INJURY OCCUR?		21qj. HOW DID INJURY OCCUR?	
21qk. HOW DID INJURY OCCUR?		21ql. HOW DID INJURY OCCUR?	
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BUREAU V. S.

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10994

CERTIFICATE OF DEATH

10966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>35 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>RFD # One, Box 305</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>E.</b> Last <b>ANDERSON, JR.</b>				4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 22, 1894</b>		9. AGE (In years last birthday) yrs. <b>61</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Academy</b>		11. BIRTHPLACE (State or foreign country) <b>Conowingo, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John E. Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Anna Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1 CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
1. <b>Post operative wound infection, left herniorrhaphy incision.</b>							
2. <b>Left hydrocele</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 2, 1956</b> , to <b>November 6, 1956</b> , and that death occurred at <b>9:35 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>C. J. Papastrat M.D. Fort Howard, Maryland 11/7/56</b>							
ACTUAL SIGNATURE <b>C. J. Papastrat M.D.</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>11/7/56</b>							
PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 11 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Tabor Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. B. Johnson Funeral Home, 34 Lafayette St. Annapolis, Md.</b>				24a. REC'D BY REGISTRAR <b>Nov 8 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farley</b>	

BUREAU V. S.

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RECEIVED

## 10995 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>2124 E. Jefferson St.</b>			
3. NAME OF DECEASED (Type or print) First <b>LEO</b> Middle <b>(NMI)</b> Last <b>ANTOS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/11/91</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tailor Shop</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Antos</b>				14. MOTHER'S MAIDEN NAME <b>Mary Neuman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <input checked="" type="checkbox"/> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>215-09-1150</b>		17. INFORMANT Address <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUBARACHNOID HEMORRHAGE</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>15 hours</b> <b>9 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS, GENERALIZED</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 22, 1956</b> to <b>November 24, 1956</b> and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Veterans Administration Hospital</b> DATE SIGNED <b>11/25/56</b>							
ACTUAL SIGNATURE <b>Constantine J. Papastamat</b> <b>9th</b>							
PHYSICIAN'S NAME (Type) <b>CONSTANTINE J. PAPASTAMAT, M.D.</b> <b>Fort Howard, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-28-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. Cook-Blight Fun. Home</b>				ADDRESS <b>6009 Harford Rd., Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 3 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Russell L. Fisher</b>			

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# STATE OF CALIFORNIA DEPARTMENT OF HEALTH - SANITATION DEATH CERTIFICATE

BUREAU V. S.

DEC 3 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 - may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 - may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 - may be retained by the hospital or attending physician.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10996 CERTIFICATE OF DEATH

10968.

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. STREET ADDRESS <u>3428 Childs Court</u>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>(NMI)</u> Last <u>ATKINSON, Jr.</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/9/24</u>
9. AGE (In years last birthday) <u>32</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Atkinson, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Maude Calhoun</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>256-22-9337</u>	
17. INFORMANT <u>Clin.Recs.Vets.Admin.Hospital,Ft.Howard,Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RETROPERITONEAL SARCOMA</u> DUE TO 158X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 30</u> , 19 <u>56</u> , to <u>November 9</u> , 19 <u>56</u> , and that death occurred at <u>10:00PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>C. J. Papastrat M.D.</u> M.D. <u>Veterans Administration Hospital</u> <u>11/11/56</u> PHYSICIAN'S NAME (Type) <u>C. J. PAPASTRAT, M.D.</u> <u>Fort Howard, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		24a. REC'D BY REGISTRAR <u>11/14/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farber</u>			



RECEIVED

10997

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethlehem Steel Co. Hospital</u>				d. STREET ADDRESS <u>3912 Pulaski Highway</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>G.</u> Last <u>BACH</u>				4. DATE OF DEATH Month <u>11</u> - Day <u>30</u> Year <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 1, 1917</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRAKEMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>R. R. SPARROWS PT.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>FRANK BACH</u>				14. MOTHER'S MAIDEN NAME <u>ROSE BECKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WORLD WART</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARIE J. BARRETT</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury of Pelvis</u> 8 m. x DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Accidentally Caught between two</u> (c), stating the underlying cause lost. <u>railroad Cars.</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Caught between two RR Cars</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11-30</u> 19 <u>56</u> p. m.				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Steel Mill</u>	
20f. (City or town) <u>Sparrows Pt</u>				20g. (County) <u>19</u>		20h. (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>12-4-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NAT. CEM.</u>	
22d. LOCATION (City, town, or county) <u>5501 FREDERICK AVE.</u>				(State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Giler</u>				ADDRESS <u>901 S. CONKLING ST.</u>		24a. REC'D BY REGISTRAR <u>Dec 3, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Lawson L. Harris</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the register prior to burial, cremation, or removal.

RECEIVED

DEC 4 1956

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10998 CERTIFICATE OF DEATH

10970  
44

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>24 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. STREET ADDRESS <b>611 N. AUGUSTA AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM M. BAGNALL</b>		4. DATE OF DEATH Month Day Year <b>November 5, 19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-7-80</b>
9. AGE (In years lost birthday) <b>76</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Company</b>	
11. BIRTHPLACE (State or foreign country) <b>New York State</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT G. BAGNALL</b>		14. MOTHER'S MAIDEN NAME <b>AMANDA MYER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> <b>Spanish Amer.</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT Address <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RECTUM WITH METASTASIS TO LIVER</b> <b>1544x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>Operation: 10/30/56 Sigmoid</b> <b>Colostomy-Carcinoma, rectum</b>			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 12, 19 56</b> , to <b>Nov. 5, 19 56</b> , and that death occurred at <b>5:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, MARYLAND 11/6/56</b>			
ACTUAL SIGNATURE <b>Milton Ginsberg</b> M.D.		PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M.D., Acting Chief, Surgical Service</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>11/8/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LODGE PARK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. Tickner &amp; Sons, North &amp; Pennsylvania Aves., Baltimore, Maryland</b>		24a. READ BY REGISTRAR DATE <b>Nov. 7, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>L. Harrison</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3. It is detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
U. S. A.

NOV 1957

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U. S. A.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10999 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10971

Reg. Dist. No. *4*

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lovely</u>			c. LENGTH OF STAY IN 1b _____	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phila.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pulaski Highway</u>				d. STREET ADDRESS <u>2216 N. Cleveland St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>IRA</u> <u>BANKS</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Nov.</u> <u>26</u> <u>19 56</u>		<b>5. SEX</b> <u>Male</u>	
<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>June 9, 1916</u>		<b>9. AGE</b> (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Cape Charles, Va.</u>		
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>George R. Banks</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Awilda</u>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)				
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Alston Goodwin</u>		Address <u>Cape Charles, Va.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Head injury</u> <u>816 x</u> <u>CRACK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushing injury of chest</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>					
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <u>Auto-truck collision</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>xxx</u> <u>11/25/ 1956</u> p. m.					
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>street</u>		<b>20f. (City or town)</b> (County) (State) <u>Balto. Md.</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>William V. Lovitt, Jr.</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>11/29/56</u>	
<b>EXAMINER'S NAME (Type)</b> <u>William V. Lovitt, Jr., M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Motored</u>		<b>22b. DATE THEREOF</b> <u>11/26/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cape Charles, Va.</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Cape Charles, Va.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Mrs. Katie R. Williams</u>				<b>24a. REC'D BY REGISTRAR</b> <u>Nov. 28, 56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Huntington Was., M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Ch of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, crematorium or removal.

1956

2518 W. 11th St.

BUREAU OF

DEC 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11000

## CERTIFICATE OF DEATH

10972

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>4601 Pall Mall Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Isaac</b> Middle <b>Bartz</b> Last <b>Bartz</b>		4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>19 56</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1880?</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR: Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
(b) <b>Acute cardiac failure</b>			
DUE TO			
(c) <b>Arteriosclerotic cardiovascular disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 9, 1956</b> to <b>Nov. 15, 1956</b> , that I last saw the deceased alive on <b>Nov. 15, 1956</b> , and that death occurred at <b>9:05a. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>11-15-56</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Spec. 6a) <b>Burial</b>		22b. DATE THEREOF <b>11-16-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis</b>		24a. REC'D BY REGISTRAR <b>16 1956</b>	
ADDRESS <b>2100 Catow Place</b>		24b. REGISTRAR'S SIGNATURE <b>F. E. Barry</b>	

BUREAU V. S.

ON

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11001 CERTIFICATE OF DEATH

10973

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>4044 Wilkins Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EMORY</b>		First <b>E</b>		Last <b>BEACH</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/26/18</b>		9. AGE (In years last birthday) yrs <b>37</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware Supply</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Beach</b>				14. MOTHER'S MAIDEN NAME <b>Anna Elizabeth Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO <b>218-01-3610</b>		17. INFORMANT Address <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>100.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 18, 1956</b> to <b>November 24, 1956</b> , that I saw the deceased <b>11/25/56</b> and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Veterans Administration Hospital 11/25/56</b>							
ACTUAL SIGNATURE <b>G. Godfrey</b>		M.D. <b>Veterans Administration Hospital 11/25/56</b>					
PHYSICIAN'S NAME (Type) <b>G. GODFREY, M.D.</b>		Fort Howard, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-28-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Truman Schwab</b>				24a. REC'D BY REGISTRAR <b>DATE 11/27/56</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Lacey</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director.



BUREAU V. S.

1900

# MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

11002

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10974

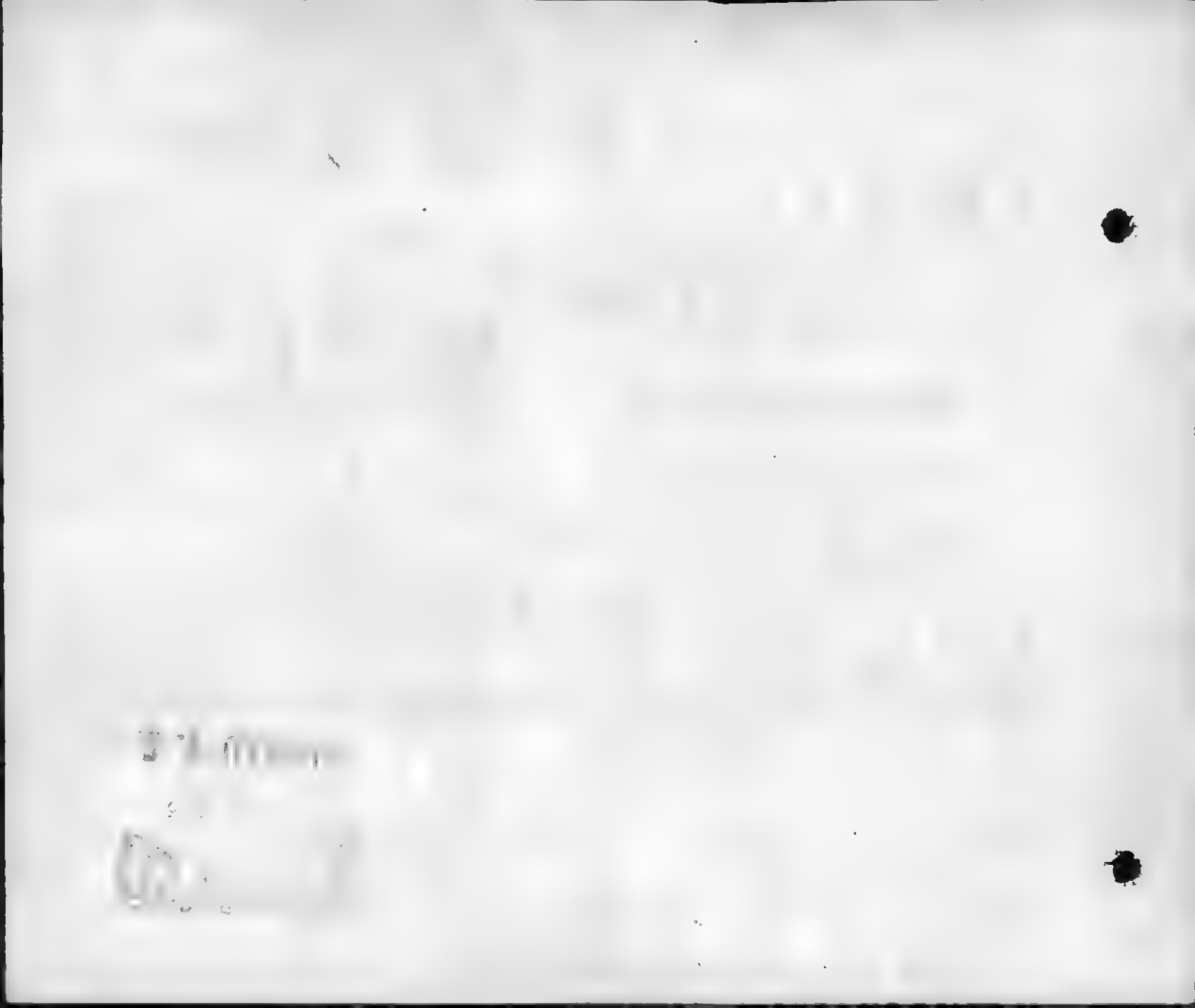
Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY <u>Ba/10</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. LENGTH OF STAY IN 1b <u>44 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>409 Back River Neck Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Isabelle Bedford</u>				4. DATE OF DEATH Month Day Year <u>11 18 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Borden Brown</u>				14. MOTHER'S MAIDEN NAME <u>Olivie Greffen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>Hypertensive Cardiovascular Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>44 yrs</u> (c) <u>44 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>44 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
NAME (Type) <u>JACK R COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-21-56</u>		<u>St Stevens md</u>		<u>Essex md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>1000</u>				24a. REC'D BY REGISTRAR DATE <u>11-23-56</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Purley</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11003

## CERTIFICATE OF DEATH

Reg. Dist. No.

1097544

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lodge Forest Home</u>				d. STREET ADDRESS <u>1908 Wareham Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>A.</u> Last <u>Belitski</u>				4. DATE OF DEATH Month <u>November</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Ca u</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1870</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Chaney</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Wilbur Kellum</u>		Address <u>1908 Wareham Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>White Cornary Insufficiency</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Ht. Disease</u> DUE TO (c) <u>Scabitis Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>4 yrs</u> <u>6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>Nov 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 4</u> , 19 <u>56</u> , and that death occurred at <u>2 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James T. Means</u>				ADDRESS (Street, city or town, state) <u>570 D St Baltimore Md</u>		DATE SIGNED <u>11/6/56</u>	
PHYSICIAN'S NAME (Type) <u>James T. Means</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home</u>				ADDRESS <u>4210 Belair Road</u>		24a. REC'D BY REGISTRAR <u>WV 8</u> DATE <u>11/6/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Lawson L. Larkins</u>			

U. S. A.

1956

RECEIVED



## 11004 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived) II institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>13yrs7mth2ldys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>4527 Arabia Avenue - Balto. Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Thomas</b> First <b>Bily</b> Middle <b>Bily</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1880</b>
9. AGE (In years last birthday) <b>76 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>conduit layer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Bohemia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Bily</b>		14. MOTHER'S MAIDEN NAME <b>Mary Stulik</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abscess left temporal lobe</b> <b>121</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Chronic purulent mastoiditis</b> DUE TO (c) <b>Chronic suppurative otitis media</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 24, 1956</b> , to <b>Nov. 28, 1956</b> , that I last saw the deceased alive on <b>Nov. 28, 1956</b> , and that death occurred at <b>5:10 p. m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D. <b>SPRING GROVE STATE HOSPITAL 11-29-56</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Nov 30-56 Oak Hill</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Horners Lane Balto. Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. J. P. 7110 Belgin Rd</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE 12-3-56</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 5. It should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

RECEIVED

109778

## 11005 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED  
(Type or Print)

Mrs. Anna Ehrhardt Bishop

2. DATE  
OF  
DEATH

Nov. 24 1956

3. PLACE OF DEATH

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

7851 Birmingham Road

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7851 Birmingham Avenue

c Length of stay in Baltimore

Yrs  
Mos  
Days

5 SEX

6 COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

female

white

married

Aug. 17, 1889

67

10A. USUAL OCCUPATION (Give kind of

work done during most of working life, even if ret. red)

10B. KIND OF BUSINESS OR  
INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

Isadore Ehrhardt

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO

17. INFORMANT

ADDRESS

Mr. Frank E. Bishop, 7851 Birmingham

18. 425.0

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST

(B)

DUE TO

(C)

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

myocardial infarction sudden

arterio sclerotic heart disease

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT

Chronic diverticulitis

3-4-78

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐21a. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21b. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21c. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

19

, that (I) (we) last saw the deceased alive on

19

and that death occurred at

m., from the causes and on the date stated above.

23a. SIGNATURE

ATTENDING PHYS. ☐MED. DIRECTOR ☐STAFF PHYS. ☐

M.D.

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMA-

TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

Burial

11/27/1956

Holy Redeemer Cem.

Baltimore, Maryland

DATE RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

LOCAL REGISTRAR

11/27/1956

Leonard J. Ruck

5305 Harford Road.

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and let HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

MIL. CERTIFICATION

BUREAU OF

OV 1956

RECEIVED

## 11006 CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>302 Dixie Drive</b>				d. STREET ADDRESS <b>302 Dixie Drive #4</b>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>F.</b> Last <b>BONSALL</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 23, 1876</b>	9. AGE (In years last birthday) yrs <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Ass't Treasury</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Gas &amp; Electric</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>? unknown</b>				14. MOTHER'S MAIDEN NAME <b>? unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>Mr. R. Stewart Bonsall-103 Tyrone Road #12</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemiplegia</b> DUE TO <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b> DUE TO (c) <b>?</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>✓</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>✓</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 14, 1935</b> , to <b>Nov. 10, 1956</b> , that I last saw the deceased alive on <b>10<sup>th</sup></b> , 1956, and that death occurred at <b>2:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1820 Eulan place</b> DATE SIGNED <b>Michael A. Abrams</b>							
ACTUAL SIGNATURE <b>Michael A. Abrams</b> M.D.				PHYSICIAN'S NAME (Type) <b>Michael A. Abrams</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/13/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Koenig &amp; Sons</b>				ADDRESS <b>1700 E. 17th St.</b>		24a. REC'D BY REGISTRAR <b>DATE Nov 13, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Michael Gray</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. E.

1950

1950

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11007 CERTIFICATE OF DEATH

10979  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard,</b>				c. LENGTH OF STAY IN 1b <b>63 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>3396 Dulaney Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM E BORDEN</b>				4. DATE OF DEATH Month Day Year <b>November 1 1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/94</b>	9. AGE (In years last birthday) <b>61 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GRINDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber Supply</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Borden</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Kline</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-I 212 07 5981</b>		17. INFORMANT Address <b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GLIOMA OF RIGHT CORPUS COLLOSUM</b> <b>193x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 30, 1956</b> , to <b>November 1, 1956</b> , the death occurred on <b>November 1, 1956</b> , at <b>6:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH, FORT HOWARD, Md. 11/2/56</b>							
ACTUAL SIGNATURE <b>C. J. Papastrat</b> M.D.				PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-5-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Ave. Balto, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight Inc.</b>				24a. REC'D BY REGISTRAR <b>Nov 7 1956</b>			
ADDRESS <b>6009 Harford Rd. Balto, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farber</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU K. T.

NOV 2 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11008

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10980  
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Texas</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Penna. R.R. Tracks</b>				d. STREET ADDRESS <b>Beaver Dam Road near Texas Lane</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>GAGLIANO</b> Middle <b>BOSLEY</b> Last				4. DATE OF DEATH <b>November 9, 1956</b> Month <b>November</b> Day <b>9</b> Year <b>19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 13, 1916</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Joseph Gagliano</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Viola Gagliano</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Crushing Injury of Skull</b> <b>(Crushed Beneath Railroad Train)</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ran into Side of Railroad Engine Pulled beneath wheels.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 12, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Texas, Balto. Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Son</b>				ADDRESS <b>Towson, Maryland</b>		24a. REC'D BY REGISTRAR <b>11</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mabel Gump</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3 A

CERTIFICATE OF DEATH

Reg. Dist. No. 30

11009

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Sparrows Point</b>			
c. LENGTH OF STAY IN 1b <b>11mths9days</b>				d. STREET ADDRESS <b>211 F. Street Gateway/Mrs. Home/Hagerstown, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>I.</b> Last <b>Bowhay</b>				4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>19 56</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 8, 1884</b>		9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipyard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>		11. BIRTHPLACE (State or foreign country) <b>Washington</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>02-006-0347</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>Arteriosclerosis, generalized and severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c) <b>Arteriosclerosis, generalized and severe</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec. 10, 1955</b> , to <b>Nov. 19, 1956</b> , that I last saw the deceased alive on <b>Nov. 19, 1956</b> , and that death occurred at <b>5:45a M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachler</b> M.D.				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>11-19-56</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-23-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Luck</b> ADDRESS <b>530 E. Harford</b>				24a. REC'D BY REGISTRAR <b>DATE 11-23-56</b>		24b. REGISTRAR'S SIGNATURE <b>Victor C. Harry</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11010

## CERTIFICATE OF DEATH

109824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>98 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d STREET ADDRESS <b>2211 W. Saratoga Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ISIAH</b> Middle <b>(NMI)</b> Last <b>BROOKS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/20/08</b>	
9. AGE (In years last birthday) <b>48 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cement Finisher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Ottoman, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James Brooks</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-II</b>				16. SOCIAL SECURITY NO. <b>230 12 4011</b>		17. INFORMANT Address <b>Glin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HODGKINS DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>July 26</b> , 19 <b>56</b> , to <b>November 1</b> , 19 <b>56</b> , that I last saw the deceased <b>12:30A</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MD.</b> DATE SIGNED <b>11/2/56</b>							
ACTUAL SIGNATURE <b>Irving Freeman</b> M.D.							
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Acting Chief Medical Service</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law Mortuary 802-04 Madison Ave. Baltimore, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Lawrence L. Lister</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1956 4 10

TELETYPE

11011

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo. Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1mth 4dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b>			
f. STREET ADDRESS <b>408 Greenlawn Drive</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Cecilia</b> Middle <b>Grace</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>19 56</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 30, 1886</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>			
11. BIRTHPLACE (State or foreign country) <b>Vermont</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John R. Hanlon</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Hall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pyelonephritis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute urinary cystitis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 12, 1956</b> , to <b>Nov. 19, 1956</b> , that I last saw the deceased alive on <b>Nov. 19, 1956</b> , and that death occurred at <b>2:20 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>		DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 11-19-56</b>					
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		ADDRESS (Street, city or town, state) <b>Catonsville 28, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-23-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>				ADDRESS <b>3821 14th St. N.W.</b>		24a. REC'D BY REGISTRAR <b>DATE 11-23-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Victor C. Harry</b>			

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED



10984

MARYLAND

STATE DEPARTMENT OF HEALTH

## 10982 CERTIFICATE OF DEATH

Reg. Dist. No. ( )

1. PLACE OF DEATH- COUNTY <u>Lansdown Balto County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>(Lansdown) Balto Co</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lansdown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>204 Hillsdale Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Michael</u> (Middle) <u>C</u> (Last) <u>Buckingham</u>		(Month) <u>II</u> (Day) <u>26</u> (Year) <u>19</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-14-1870</u>
9. AGE last birthday <u>36</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dr. L. Baker</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ezra Buckingham</u>		14. MOTHER'S MAIDEN NAME <u>Felicia Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>30</u>		16. SOCIAL SECURITY No. <u>30</u>	
17. INFORMANT AND ADDRESS <u>Mrs Lottie B Bucking 204 Hillsdale Ave</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) <u>Carcinoma of the Larynx</u>			
(b) <u>Immediate cause</u>			
(c) <u>Antecedent cause(s)</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE)	
22. I hereby certify that I attended the deceased from <u>Oct 1956</u> , to <u>Nov 26, 1956</u> , that I last saw the deceased alive on <u>Nov 26, 1956</u> , and that death occurred at <u>2:30 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Edward Toulson</u> (Degree or title) <u>M.D.</u>		ADDRESS <u>2436 Washington Blvd Balto Md</u>	
DATE SIGNED <u>11/27/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CFMETERY OR CREMATORY <u>Melville Cemetery</u>	
DATE <u>11-29-56</u>		LOCATION (City, town, or county) <u>Elkridge Howard Co Md</u>	
DATE REC'D BY LOCAL REG. <u>11-22-56</u>		24. FUNERAL DIRECTOR <u>Edward Toulson</u> ADDRESS <u>2359 Wash Blvd Balto 30</u>	

MARGIN RESERVED FOR BINDING

11/8/51

1  
 THE DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10983

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>		c. LENGTH OF STAY IN 1b <b>life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2200 ... Court</b>			d. STREET ADDRESS <b>918 Catawba Ct.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BURNETT</b> Middle <b>de</b> Last <b>BURNOPP</b>			4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1906</b>	9. AGE (in years last birthday) yrs. <b>5</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>...</b> Hours <b>...</b> Min. <b>...</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Thomas W. Burnopp</b>			14. MOTHER'S MAIDEN NAME <b>Patricia D. Ries</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Thomas W. Burnopp 918 C. t Court</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>391.2</b> IMMEDIATE CAUSE (a) <b>Bilateral Otitis Media</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Hour <b>...</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from <u>natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>William V. Lovitt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/9/56</b>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>11/18/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of the Fields</b>		22d. LOCATION (City, town, or county) (State) <b>Willsboro, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>...</b>		ADDRESS <b>...</b>		24a. REC'D BY REGISTRAR <b>...</b> DATE <b>...</b>	
				24b. REGISTRAR'S SIGNATURE <i>Geo. M. Jeffers</i>	

203-18-211

BOHNER A. S.

1901

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11012

CERTIFICATE OF DEATH

10986 30

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b <b>7 mo 11 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cottage City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>3705-40th Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Homer</b> Middle <b>Kirk</b> Last <b>Butler</b>		4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-25-89</b>
9. AGE (In years last birthday) <b>67</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Marcellus Butler</b>		14. MOTHER'S MAIDEN NAME <b>Jane Ann Dean</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give year or dates of service]		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Hospital records, Spring Grove Hosp., Catonsville</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of myocardium</b> DUE TO <b>Arteriosclerotic Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>o. 11</b> Month, <b>19</b> Day, <b>19</b> Year p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 29</b> , 19 <b>56</b> , to <b>Nov. 10</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov. 10</b> , 19 <b>56</b> , and that death occurred at <b>11:40A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louie Frances Woodward</b>		ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital, Catonsville</b>	
PHYSICIAN'S NAME (Type) <b>Louie Frances Woodward, M. D.</b>		DATE SIGNED <b>11-10-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>11-13-56</b>	<b>mt. Olivet</b>	<b>Washington D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Valley's Funeral Home</b>		ADDRESS <b>mt. Rainier</b>	24. REC'D BY REGISTRAR <b>Nov 12-56</b>
		24b. REGISTRAR'S SIGNATURE <b>J. E. Harris</b>	

BUREAU V. 1

27 15 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10987

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

44

11013

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sparrows Point Hospital</b>		d. STREET ADDRESS <b>2904 Baker St. Baltimore 16, Md.</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Campbell</b> Last <b>Jr.</b>		4. DATE OF DEATH Month <b>11</b> Day <b>1</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 5 1905</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Campbell sr.</b>		14. MOTHER'S MAIDEN NAME <b>Emley Chinn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>m</b>		16. SOCIAL SECURITY NO. <b>222-70-8436</b>	
17. INFORMANT <b>Lucille Campbell</b>		Address <b>2904 Baker St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>422.0.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>12</b> p. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>END OF</b>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. Davis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-4-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>mt kerson cem.</b>		22d. LOCATION (City, town, or county) (State) <b>White Stone Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. S. Nelson</b>		24a. REC'D BY REGISTRAR <b>Nov 2, 1956</b>	
ADDRESS <b>1348 N. Calhoun St</b>		24b. REGISTRAR'S SIGNATURE <b>Nelson L. Lasker</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

BUREAU V. S.

1956

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RECEIVED



11014

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>400 Carolina Road</b>		e. STREET ADDRESS <b>400 Carolina Road</b>	
3. NAME OF DECEASED (Type or print) <b>ZERA</b> First <b>CANNADAY</b> Middle Last		4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1899</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager of Office</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Finance Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaac T. Cannaday</b>		14. MOTHER'S MAIDEN NAME <b>Lacy Peters</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Family Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Nov. 26, 1956</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Brain atrophy 2. Generalized wasting</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 6, 1954</b> to <b>Nov 25, 1956</b> , that I last saw the deceased alive on <b>Nov 27, 1956</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund F. Cotten</b>		ADDRESS (Street, city or town, state) <b>6 E. Reed St. Balto. Md.</b>	
PHYSICIAN'S NAME (Type) <b>Edmund F. Cotten</b>		DATE SIGNED <b>Nov 28, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 30, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Parkville, Maryland</b>	
23. FURNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons</b>		24a. REC'D BY REGISTRAR <b>Nov 28, 1956</b>	
ADDRESS <b>Towson, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death. Pages 1 and 2 should be filed with the funeral director.

U.S. AIR FORCE

NO

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# MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10989

Reg. Dist. No. 30

110'5

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>633 Aldershot Road</u>				d. STREET ADDRESS <u>633 Aldershot Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Joseph</u> <u>Childs</u> <span style="float: right;">Last</span>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>26</u> Year <u>56</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Whitr</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec. 9, 1883</u>	
<b>9. AGE</b> (In years last birthday) <u>72</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min		<b>IF UNDER 24 HRS.</b> Hours Min		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Machine</u> <u>Shirt factory</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>George Childs</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Joe Graw</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give was or dates of service) <u>No</u>		<b>17. INFORMANT</b> <u>Margaret Childs, 633 Aldershot Rd.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <u>420.1</u> DUE TO <u>Coronary Thrombosis</u>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }  <b>DUE TO</b> <u>Coronary Thrombosis</u>            (c)         </div> <div style="width: 35%; border: 1px solid black; padding: 5px;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>    </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <u>Geo. S. M. Kieffer</u> <span style="float: right;">M.D.</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>Geo. S. M. Kieffer</u> <span style="float: right;">M.D.</span>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>Nov. 26, 56</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>22b. DATE THEREOF</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b>		<b>22d. LOCATION (City, town, or county)</b> (State)	
<u>Burial</u>		<u>11/29/56</u>		<u>Holy Redeemer</u>		<u>Balto., Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Mac Hattison</u> <span style="float: right;">Catonsville 28</span>				<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>V.E. Harry</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

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RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11016 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10990

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b <u>Baltimore 141</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 141</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenn L. Martin Co.</u>			d. STREET ADDRESS <u>3530 Woodring Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <u>William H. Chisholm</u>			<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>21st</u> Year <u>1956</u>		
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>July 7, 1907</u>	<b>9. AGE</b> (In years last birthday) <u>49 yrs.</u>	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer Glenn L. Martin</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Ripley, Tennessee</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>Robert Chisholm</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Belle White</u>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>199-01-9086</u>		<b>17. INFORMANT</b> Address <u>Mrs. Mary Frances Chisholm, 3530 Woodring</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> p. m. <u>  </u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <u>Jack C. Collins</u>			<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>11-21-56</u>
<b>EXAMINER'S NAME (Type)</b> <u>JACK C. COLLINS</u>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11/26/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Parkwood Cemetery</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Leonard J. Ruck</u>		<b>ADDRESS</b> <u>5305 Harford Road #14</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Edith Hurley</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>					

THIS DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registration prior to burial, cremation, or removal.

BUREAU V. S.

NOV 26 1951

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10991

## 11017 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>608 North Bond Rd.</b>		d. STREET ADDRESS <b>608 North Bond Rd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Fannie Lavinia Clark</b>		4. DATE OF DEATH Month Day Year <b>Nov. 29, 1956</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1875</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>T.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Zacharias Jacobs</b>		14. MOTHER'S MAIDEN NAME <b>Mary Louise</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Mary Frank</b>		Address <b>608 North Bond Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 1948, to <b>Nov. 26</b> , 1956, that I last saw the deceased alive on <b>Nov. 26</b> , 1956, and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1 Mallow Hill Ave., Balto., Md.</b> DATE SIGNED <b>11/30/56</b> ACTUAL SIGNATURE <b>Leo J. Gaver</b> M.D. PHYSICIAN'S NAME (Type) <b>Leo J. Gaver, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 1/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witte</b>		24a. REC'D BY REGISTRAR DATE <b>12/3 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11018

## CERTIFICATE OF DEATH

10992

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>890 E. Joppa Road</b>		d. STREET ADDRESS <b>830 E. Joppa Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JANE ELIZABETH CLARK</b>		4. DATE OF DEATH Month Day Year <b>November 11, 1956 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 20, 1913</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
13. FATHER'S NAME <b>George L. Gaines</b>		14. MOTHER'S MAIDEN NAME <b>Ida B. Boller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	17. INFORMANT <b>Family records</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ureteral obstruction</b> DUE TO (c) <b>Carotid Artery Aneurysm</b>			INTERVAL BETWEEN ONSET AND DEATH <b>17 mos</b> <b>3 mos</b> <b>7 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 11, 1956</b> to <b>Nov 11, 1956</b> , that I last saw the deceased alive on <b>Oct 23, 1956</b> , and that death occurred at <b>12:30 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gerald A. Galvin</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>1137 Monument St Baltimore MD 11/12/56</b>	
PHYSICIAN'S NAME (Type) <b>GERALD A. GALVIN</b>		<b>Baltimore MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 13, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Parkville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burne Lona</b>		ADDRESS <b>Towson, Maryland</b>	
24a. REC'D BY REGISTRAR <b>11/13/56</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	

BUREAU V. S.

NOV 15 1936

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11019 CERTIFICATE OF DEATH

Reg. Dis. 10993 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>41 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
		d. STREET ADDRESS <b>449 E. 28th Street</b>	
3. NAME OF DECEASED (Type or print) <b>ERIC</b> First (Downing) Last <b>CLAYTON</b>		4. DATE OF DEATH <b>November 15</b> 19 <b>56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 12, 1907</b> 49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Service Photo Supply Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Clayton</b>		14. MOTHER'S MAIDEN NAME <b>Emma Heiss</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type or print) <b>Yes</b> (If yes, give war, dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>214-01-2444</b>	
17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SQUAMOUS CELL CARCINOMA OF THE TONGUE WITH METASTASIS</b> 141X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>6 WEEKS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 2</b> , 19 <b>56</b> , to <b>Nov. 15</b> , 19 <b>56</b> , and that death occurred at <b>1:26 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>R. D. Ponce de Leon</b>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>11/15/56</b>	
PHYSICIAN'S NAME (Type) <b>R. D. PONCE de LEON, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/19/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Tickner &amp; Sons, North and Penna. Ave. Balto. Md.</b>		24. REC'D BY REGISTRAR <b>150</b>	
		25. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, and completely filled out by the funeral director, by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956

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1956

## 11020 CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>49 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>204 Church Lane</b>		d. STREET ADDRESS <b>204 Church Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Corbin Carroll Cogswell</b>		4. DATE OF DEATH Month Day Year <b>Nov, 7 1956</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7, 1885</b>
9 AGE (In years last birthday) yrs. <b>71</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Builder</b>	
11. BIRTHPLACE (State or foreign country) <b>Wash, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles F. Cogswell</b>		14. MOTHER'S MAIDEN NAME <b>Emily Rawlings</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-10-3298</b>	
17. INFORMANT <b>William J. Cogswell, Pikesville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>myocardial infarction, acute</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> to <b>7 Nov</b> , 1956, that I last saw the deceased alive on <b>Oct 22, 1956</b> , and that death occurred at <b>11:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Pikesville 8 Md</b> DATE SIGNED <b>8 Nov 56</b>			
ACTUAL SIGNATURE <b>Paul H Royse</b>		M.D. <b>Paul H Royse MD</b>	
PHYSICIAN'S NAME (Type) <b>Paul H Royse MD</b>		<b>Pikesville 8 Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Jewell - Pikesville, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov 13 1956</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Anthony Jewell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NON

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10995

## 10968 CERTIFICATE OF DEATH

Reg. Dist. No. .... 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK 22</u>		LENGTH OF STAY (in this place) <u>28 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK 22</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11 FLAGSHIP ROAD</u>				STREET ADDRESS (If rural give location) <u>11 FLAGSHIP ROAD</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>HATTIE HARDY COLEMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11-7-52</u>			
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCT. 24, 1889</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>G. W. HARDY 213-07-4900 B.</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET W. HARDY TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Bnk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>B. D. COLEMAN - SAME ADDRESS</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>15 min</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10</u> to <u>1956</u> , to <u>11-7</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>11-2</u> , 19 <u>52</u> , and that death occurred at <u>6:50 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>John O. Callins, M.D.</u>		DATE THEREOF <u>11-10-56</u>		NAME OF CEMETERY OR CREMATORY <u>DAK LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO. Co. MD</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR <u>John O. Callins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Smith</u>		DATE SIGNED <u>11-9-52</u>	

BUREAU N. S.

1906

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be for and to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

KNOWN Cardiac - J. H. Hagg.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10996	
11021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										40	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTIMORE</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White MARSH</b>					c. LENGTH OF STAY IN 1b						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Red lion</b>					d. STREET ADDRESS <b>Red lion</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>A.</b> Last <b>Couplin</b>					4. DATE OF DEATH Month <b>11</b> Day <b>26</b> Year <b>1956</b>						
5. SEX <b>M</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-3-1883</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>James Couplin</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Gram</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Mrs. Elizabeth Couplin - some</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest.</b> 444.1 DUE TO <b>Myocardial Degeneration Severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Advanced Arteriosclerotic Cardiovascular Dis. Underl.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Smoking General, Scurvy &amp; Emphysema.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John C. Hyle</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <b>11-27-56</b>	
EXAMINER'S NAME (Type) <b>JOHN C. Hyle</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>11-29-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Loreley, Balto. Co., Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Frances A. Hensley</b>					ADDRESS <b>Biader St.</b>		24a. REC'D BY REGISTRAR <b>Dr. Walter Hammett</b>		24b. REGISTRAR'S SIGNATURE		

BUREAU V. S.

JUN 1950

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10997				
11022 <i>Baltimore County</i>										Reg. Dist. No. <i>38</i>				
CERTIFICATE OF DEATH														
1. PLACE OF DEATH <i>3004 Duboise Ave</i> a. COUNTY <i>Parkville Md.</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Parkville</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS <i>3004 Duboise Ave</i>					e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First <i>Rosalia</i>		Middle		Last <i>Cremona</i>		4. DATE OF DEATH Month <i>November</i> Day <i>28</i> Year <i>1956</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 11 1867</i>		9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Palermo-Sicily-Italy</i>			12. CITIZEN OF WHAT COUNTRY? <i>Italy</i>					
13. FATHER'S NAME <i>Rosario Di Chiara</i>						14. MOTHER'S MAIDEN NAME <i>Vita Romano</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mary Gilda Cremona 3004 Duboise Ave</i>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> <i>L.O.O.</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerotic heart disease</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i> <i>May 1956</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <i>September, 1936</i> , to <i>November, 1956</i> , that I last saw the deceased alive on <i>Nov. 28, 1956</i> , and that death occurred at <i>11 P. M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>William Harris</i> M.D. <i>Nov 14, 1956</i> PHYSICIAN'S NAME (Type) <i>S.E. Harris</i>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec. 1st 1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>				22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>James T. H. H. H.</i>						ADDRESS <i>322 S. High St.</i>		24a. REC'D BY REGISTRAR DATE <i>12-3-56</i>		24b. REGISTRAR'S SIGNATURE <i>W. M. Bacon</i>				

RECEIVED

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RECEIVED

## 11023 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1815 Colonial Road</b>		d. STREET ADDRESS <b>1815 Colonial Rd</b>	
3. NAME OF DECEASED (Type or print) <b>Caroline K. Crichton</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>5</b> Year <b>1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1869</b>
9. AGE (In years last birthday) <b>87</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>? Kahler</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give year or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>414.14.1368A</b>		17. INFORMANT <b>John P. Crichton</b> Address <b>1815 Colonial Rd. 7</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Cardio-Vascular Disease</b> DUE TO (c) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>47</b> , to <b>Nov. 5</b> , 19 <b>56</b> that I last saw the deceased alive on <b>Nov. 4</b> , 19 <b>56</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Morris W. Steinberg</b> M.D. PHYSICIAN'S NAME (Type) <b>MORRIS W. STEINBERG</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/8/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd</b>	
24a. REC'D BY REGISTRAR <b>NOV 7 1956</b>		24b. REGISTRAR'S SIGNATURE <b>A. M. E. Martinez</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 2 1901

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11024 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10999 *28*  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b <b>11 Days</b>				<b>Shepherdstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sheppard and Enoch Pratt Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SERENA</b> Middle <b>KATHERINE</b> Last <b>DANDRIDGE</b>				4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1877</b>		9. AGE (in years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adam S. Dandridge</b>				14. MOTHER'S MAIDEN NAME <b>Caroline D. Bedinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia secondary to Strangulation</b> <b>974X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hanged self</b>					
20c. TIME OF INJURY Month, Day, Year <b>11/7 1956</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.) <b>Hospital</b>		20f. (City or town) <b>Baltimore</b>		(County) (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Paul F. Guerin</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/7/56</b>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11/7/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>-</b>		22d. LOCATION (City, town, or county) (State) <b>Shepherdstown, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Pickner &amp; Sons - Balt 17, Md.</i>				ADDRESS		24a. RECEIVED BY REGISTRAR DATE <b>Nov. 8, 1956</b>	
						24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU W. L.

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11025 CERTIFICATE OF DEATH

11000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>341 Nicholson Ave.</b>				d. STREET ADDRESS <b>341 Nicholson Ave.,</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>DANINI</b> Last				4. DATE OF DEATH Month <b>NOV.</b> Day <b>2ND</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/13/81</b>		9. AGE (In years last birthday) <b>75</b> yrs	IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>19</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cement Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cement Business</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John D. Danini</b>				14. MOTHER'S MAIDEN NAME <b>Celeste Cerri</b>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-05-1276</b>		17. INFORMANT <b>Mrs. Caroline Danini</b>		Address <b>Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tumor, anterior mediastinum, Teratoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>257X</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. p.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 14</b> , 19 <b>56</b> , to <b>Nov. 2</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov. 2</b> , 19 <b>56</b> , and that death occurred at <b>9:00p</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8019 Philadelphia Rd. Balt. 6, Md.</b> DATE SIGNED <b>11-5-56</b>							
ACTUAL SIGNATURE <b>James R. Mason M.D.</b>		PHYSICIAN'S NAME (Type) <b>James R. Mason, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 6th, 56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Belair Road Balto, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly</b>				ADDRESS <b>Essex, Md.</b>		24a. REC'D BY REGISTRAR <b>Edith Hurley</b>	
				DATE <b>NOV 8 1956</b>		24b. REGISTRAR'S SIGNATURE	

RECEIVED

BUREAU V. S.

11026

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Imogene</b> Middle <b>DAVID</b> Last <b>DAVID</b>				4. DATE OF DEATH Month <b>11</b> Day <b>28</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/15/49</b>		9. AGE (In years last birthday) <b>6</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>28</b> Hours <b>1956</b>	IF UNDER 24 HRS Hours <b>1956</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles David</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Powell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address <b>Mrs. Mary Bailey Nock (Mother) 605 Railroad Ave. Salisbury, Md. Rosewood Records, Owings Mills, Md. Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia, acute</b> <b>751x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute bronchitis</b> DUE TO (c) <b>Arnold Chiari Syndrome</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>since birth</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 7, 1953</b> to <b>Nov. 28, 1956</b> , that I last saw the deceased alive on <b>Nov. 28, 1956</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Owings Mills, Maryland.</b> DATE SIGNED <b>11/29/56</b>							
ACTUAL SIGNATURE <b>Harry G. Butler</b>		M.D. <b>Owings Mills, Maryland.</b> <b>11/29/56</b>					
PHYSICIAN'S NAME (Type) <b>Harry G. Butler, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>		22b. DATE THEREOF <b>Dec. 3, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverside Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Berlin, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD</b>				24a. REC'D BY REGISTRAR <b>DEC 3 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Elsie</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, if be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO 106

1954

## 11002

## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

Shipped to O.J.Douglas Funeral Home, Welch, W. Virginia



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1100344

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPRING POINT</b>				c. LENGTH OF STAY IN lb <b>50 yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11003</b>				d. STREET ADDRESS <b>1912 NEVILL RD.</b>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>*</b> Last <b>DIETER</b>				4. DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>19 56</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-14-1887</b>		9. AGE (in years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEEL WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ST. LEON. STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>CALIFORNIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN DIETER</b>				14. MOTHER'S MAIDEN NAME <b>UNK.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-07-8066</b>		17. INFORMANT <b>GEORGE E. DIETER</b> Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Jack C. Collins</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JACK C. COLLINS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-12-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE CO. MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DUNDALE 22, MD.</b>				24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <i>Samuel J. Farber</i>	

MEDICAL CERTIFICATION

TO DEPT. OF MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please excuse certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. E.

NOV 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11004

11029

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>1 Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>1216 W. Fayette Street</b>			
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>E.</b> Last <b>DIXON, SR</b>				4. DATE OF DEATH Month <b>November</b> Day <b>16</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>March 5, 1899</b>	
9. AGE (In years last birthday) yrs. <b>57</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Buildings</b>		11. BIRTHPLACE (State or foreign country) <b>Unionville, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US. A.</b>							
13. FATHER'S NAME <b>George Bates Dixon</b>				14. MOTHER'S MAIDEN NAME <b>Addie Hammond</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>215-01-1921</b>		17. INFORMANT Address <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TUBERCULOUS PERICARDITIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>12:05 A.M. 3:50 A.M.</b>				20g. (County) <b>3:50 A.M.</b>		20h. (State) <b>3:50 A.M.</b>	
21. I certify that I attended the deceased from <b>November 15, 1956</b> to <b>November 16, 1956</b> and that death occurred at <b>3:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>11/16/56</b> ACTUAL SIGNATURE <b>C. M. SNYDER, M. D.</b> PHYSICIAN'S NAME (Type) <b>C. M. SNYDER, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 20, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George H. Holland</b>				24a. REC'D BY REGISTRAR <b>Nov. 19, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>	

WINDAU A. 2

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100-100-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11005

11030 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admittance) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>713 Walker Ave.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>713 Walker Ave.</b>				d. STREET ADDRESS <b>713 Walker Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>C.</b> Last <b>DORSEY</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>12,</b> Year <b>19 56</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7, 1878</b>		9. AGE (In years last birthday) <b>88</b> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Augustus Litsinger</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Fishpaw</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Mrs. Carroll Bruehl - 713 Walker Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiac Disease</b> DUE TO <b>1096</b> (c) <b>Coronary Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1950</b> to <b>Nov 12, 1956</b> , that I last saw the deceased alive on <b>Nov 12, 1956</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.				ADDRESS (Street, city or town, state) <b>7501 7th St Baltimore, Md.</b>		DATE SIGNED <b>11/12/56</b>	
INTERVIEWER'S NAME (Type) <b>Charles F. O'Donnell</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/15/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Pickner &amp; Sons - Balt. 17, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>Nov. 14, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Walter Gray</b>	

RECEIVED

JUL 17 1956

BUREAU V. S.

11031 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3012 Acton Road</u>		d. STREET ADDRESS <u>3012 Acton Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Joseph J. Doyle</u>		4. DATE OF DEATH Month Day Year <u>November 17th 19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ireland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Doyle</u>		14. MOTHER'S MAIDEN NAME <u>Helen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Elizabeth J. Doyle, 3012 Acton Road</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> 15-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 9, 1956</u> to <u>11/17, 1956</u> , that I last saw the deceased alive on <u>11/16/56</u> , and that death occurred at <u>7:00 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1261 E. Belvedere Ave</u> DATE SIGNED <u>11/17/56</u>			
ACTUAL SIGNATURE <u>Sol Smith</u>		M.D. <u>1261 E. Belvedere Ave</u>	
PHYSICIAN'S NAME (Type) <u>Sol Smith</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/20/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Hargord Road #14</u>	
24a. REC'D BY REGISTRAR <u>Nov. 19, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Jr. A. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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9561 1956

107-108-80

## 11032 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wing Hall Baltimore 21, Md.</u>		d. STREET ADDRESS <u>2703 Orleans Street</u>	
3. NAME OF DECEASED (Type or print) <u>FANNIE</u> First Middle Last		4. DATE OF DEATH <u>Nov</u> Month <u>19</u> Day <u>1956</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Siegel</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>John Dressel, husband, above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma uterus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1 year</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/13, 1956</u> , to <u>11/19, 1956</u> , that I last saw the deceased alive on <u>11/19, 1956</u> , and that death occurred at <u>530</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. L. Kolodny, M.D.</u>		ADDRESS (Street, city or town, state) <u>1825 Eastern Blvd. Baltimore 21, Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. L. KOLODNY, M.D.</u>		DATE SIGNED <u>11/19/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 23, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimunek Funeral Home, Inc.</u>		ADDRESS <u>2601-3-5 E. Madison St.</u>	
24a. REC'D BY REGISTRAR <u>DATE 11-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## 11033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Manor Road</b>				d. STREET ADDRESS <b>Manor Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>PIERRE</b> Middle <b>CHATARD</b> Last <b>DUGAN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 10, 1912</b>	9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Ferdinand Dugan</b>				14. MOTHER'S MAIDEN NAME <b>Melanie Boone</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>3/14/33 664436 216-07-3066</b>			
17. INFORMANT <b>Wife,</b>				Address <b>Manor Rd., Balto. Co.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound of Head</b> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Shot self in head</b>			
20c. TIME OF INJURY Month, Day, Year <b>11/19 19 56</b> Hour a. m. <b>1:30</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>				20f. (City or town) (County) (State) <b>Balto. Co. Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Paul F. Guerin</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>11/19/56</b>			
22a. BURIAL CREMATION OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>11/21/56</b>		<b>Balto National</b>		<b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Stewart Mowbray</i>				24. REC'D BY REGISTRAR <b>25 DEC 1956</b>			
ADDRESS <b>108 W York - Balto</b>				24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the canteen, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11034 CERTIFICATE OF DEATH

11009

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Containsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9 N. Symington Ave.</b>				d. STREET ADDRESS <b>9 N. Symington Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LEAH</b> Last <b>DUNWOODY</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>18,</b> Year <b>1956</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 27, 1871</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Josiah Geesaman</b>				14. MOTHER'S MAIDEN NAME <b>Annie Pentz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Miss Ruth Dunwoody - 9 N. Symington Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> <b>122.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>arteriosclerotic cardiovascular disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov 16, 1956</b> to <b>Nov 18, 1956</b> , that I last saw the deceased alive on <b>Nov 16, 1956</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1115 St Paul St</b> DATE SIGNED <b>Nov 20, 1956</b>							
ACTUAL SIGNATURE <b>John A. Nesbitt Jr.</b> M.D. <b>1115 St Paul St</b>				PHYSICIAN'S NAME (Type) <b>John A. Nesbitt Jr. Baltimore 22, Ind</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/21/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harbaugh Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Franklin Co., Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. A. Schenck &amp; Sons - Balt 17 Md.</b>				24a. REC'D BY REGISTRAR <b>DATE Nov 20, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 9 Film G2-5 11-13-56 et

## CERTIFICATE OF DEATH

11010

Reg. Dist. No.

11035

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Essex)</b>				c. LENGTH OF STAY IN 1b <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>"Ivy Hall" 19 Harrison Ave.</b>				d. STREET ADDRESS <b>1720 Middleborough 19 Harrison Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Hilda</b> Middle <b>L</b> Last <b>Elder</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>2</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Approx. 53</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>53</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Chicago, Illinois</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mr. Samuel Elder, 1720 Middleborough</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarct</b> <b>431X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Potential myocarditis</b> (c) <b>Septicemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>8 mo</b> <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bleeds Disposal</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June, 1954</b> , to <b>11/2</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11/1</b> , 19 <b>56</b> , and that death occurred at <b>2 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. Blatt</b>				ADDRESS (Street, city or town, state) <b>434 Eastern Ave. Essex, Md</b>			
PHYSICIAN'S NAME (Type) <b>Dr. J. J. Platt</b>				DATE SIGNED <b>11/2/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard G. Ruck</b>				ADDRESS <b>5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR <b>1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Edith H. Hickey</b>							

U. S. DEPARTMENT OF AGRICULTURE

1906

RECEIVED

## 11036 CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE ST. HOSP.</u>				d. STREET ADDRESS <u>3704 BROOKLYN AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARIE LILLIAN ERDMAN</u>				4. DATE OF DEATH Month Day Year <u>NOV. 9 1956</u>			
5. SEX <u>FEM.</u>		6. COLOR OR RACE <u>WH.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-24-1895</u>	
9. AGE (In years last birthday) <u>61</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>EDWARD WATERS</u>				14. MOTHER'S MAIDEN NAME <u>LENA Hubbard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT <u>HARVEY C. ERDMAN</u> Address <u>3704 BROOKLYN AVE. BALTO</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-6-56</u> , 1956, to <u>11-9-</u> , 1956, that I last saw the deceased alive on <u>Nov. 9,</u> 1956, and that death occurred at <u>3:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Stella Wachslar</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> <u>11-9-56</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> <u>Catonsville 28, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 12, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ritchie Highway Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>KRAUSE FUNERAL HOME 1216 S. Charles St.</u>				24a. REC'D BY REGISTRAR <u>11-13-56</u>		24b. REGISTRAR'S SIGNATURE <u>V. E. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 1 1956

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10969 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11012**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE 22</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>104 Walnut Ave., Turner Station, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sallie ANN Falden</b>				4. DATE OF DEATH Month <b>11</b> Day <b>25</b> Year <b>1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/1906</b>	9. AGE (In years last b'irthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Terrell</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Terrell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Theodore Falden - 104 Walnut St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR</b> DUE TO <b>RENAL DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4 yrs</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C Collins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>JACK C Collins</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<b>11-25-56</b>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/28/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ME. Calvary</b>	22d. LOCATION (City, town, or county)		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>			ADDRESS <b>802 Madison Avenue</b>		24a. REC'D BY REGISTRAR <b>Nov 28 1956</b>	24b. REGISTRAR'S SIGNATURE <b>Mr. Kelly</b>	

BUREAU V. S.

NOV 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11037 CERTIFICATE OF DEATH

Reg. Dist. No.

11013

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>6 mos 1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>4905 SHERIDAN ST.</b>	
3. NAME OF DECEASED (Type or print) <b>LULA MARY FAULKNER</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>3</b> Year <b>1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-1891</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CORNELIUS KISEN</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA WINDELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Records, SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>known</b> (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETIS MELLITUS - GENERALIZED ACIDOSIS CEREOSIS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 2</b> , 19 <b>56</b> , to <b>Nov. 3</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov. 3</b> , 19 <b>56</b> , and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslor</b> M.D.		DATE SIGNED <b>Spring Grove St. Hospital</b>	
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLOR</b>		<b>Catonville 28, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>11-6-56</b>	<b>Fort Lincoln</b>	<b>Bladensburg Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. W. Chambers, Jr. Wash DC</b>		24. REGISTER'S SIGNATURE <b>W. C. Larrup</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10 11 11

CHANGEN

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11038 CERTIFICATE OF DEATH

Reg. Dis. No. **11014** 40

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>8 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1976 West Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>(NMI)</b> Last <b>FISHER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 30, 1892</b>	
9. AGE (In years last birthday) yrs <b>64</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Moving - Hauling</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Solomon Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Pricilla Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <b>WW I</b>				16. SOCIAL SECURITY NO. <b>214-05-2535</b>		17. INFORMANT <b>Clinical Records, VA Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>445X</b> IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>November 5, 1956</b> to <b>November 13, 1956</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>11/14/56</b> ACTUAL SIGNATURE <b>C. J. PAPA STRAT, M.D.</b> PHYSICIAN'S NAME (Type) <b>C. J. PAPA STRAT, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Fowlers Chapel Church</b>		22d. LOCATION (City, town, or county) (State) <b>Beth Gate, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Reese Funeral Home, 108 Washington St., Annapolis, Maryland</b>				24a. REC'D BY REGISTRAR <b>Nov. 20, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



NOV 21 1956



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A13ME(5)  
SM 9/55

11039

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS PT 19</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fisher Rd</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 22; DUNDALK</u> d. STREET ADDRESS <u>1950 Searles Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Desmond Dionigio Forti</u>		4. DATE OF DEATH Month Day Year <u>11 - 25 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 31, 1913</u>
9. AGE (in years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CRANE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel, BETHLEHEM</u>	
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROMULDO FORTI</u>		14. MOTHER'S MAIDEN NAME <u>AGNES POSTAL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>URBAN FORTI</u>		Address <u>MT. CARMEL, PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound - Chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self Inflicted Gunshot Wound (22 Cal.) Chest</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 11-28-56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>7401 GERMAN HILL RD., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Seiler</u>		ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>	
24a. REC'D BY REGISTRAR <u>Nov 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Laney</u>	

RECEIVED

NOV 28 1956

BUREAU V. S.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Ch. of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reburial.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11040

11016

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penn.</b> b. COUNTY <b>Phila.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lorelay</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phila.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fulaski Highway</b>				d. STREET ADDRESS <b>1744 N. 15th St.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FREDERICK FOSTER</b>				4. DATE OF DEATH Month Day Year <b>Nov. 26, 1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>separated</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/17/1929</b>	
9. AGE (In years last birthday) <b>27</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <b>Charolette, N.C.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>David Foster</b>				14. MOTHER'S MAIDEN NAME <b>Cleora Dawkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>Korean</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Cleora Dawkins</b>				Address <b>1923 Ridgehill Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing injury of chest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Auto-truck collision</b>			
20c. TIME OF INJURY Month, Day, Year <b>11/25/ 19 56</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>				20f. (City or town) (County) (State) <b>Balto. Md.</b>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/29/56</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Randolph J. Collick</b>				ADDRESS <b>1412 E. Preston St.</b>			
24a. REC'D. BY REGISTRAR <b>Dec 3, 1956</b>				24b. REGISTRAR'S SIGNATURE <b>Dr. Walter Hammett</b>			

MEDICAL CERTIFICATION

BUREAU A. S.

DEC 4 1950

RECEIVED

11041

## CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Layne Nursing Home, 98 Smith Road Ave</b>				e. STREET ADDRESS <b>13 Holmehurst Ave</b>			
3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle <b>N. Foster</b> Last				4. DATE OF DEATH Month <b>Nov.</b> Day <b>1</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1870</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Electric Co. Balto. Md.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Foster</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Vance</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs Earl Smallwood, 13 Holmehurst Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO <b>with Hyper Tension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO <b>5 years</b> (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 3, 1948</b> , to <b>November 1, 1956</b> , that I last saw the deceased alive on <b>October 30, 1956</b> , and that death occurred at <b>6:35 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Melvin N. Borden</b> M.D.				ADDRESS (Street, city or town, state) <b>5000 OLD FREDERICK RD BALTIMORE 29, MD.</b>			
PHYSICIAN'S NAME (Type) <b>Melvin N. Borden</b>				DATE SIGNED <b>11/2/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 3/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louden Park</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry A. Witte</b>				ADDRESS <b>4101 Edmondson Ave</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DECEMBER 1967

## 11042 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>MD</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SHARBY NOOK NURSING HOME</b>		d. STREET ADDRESS <b>1914 DEERING AVE</b>	
3. NAME OF DECEASED (Type or print) <b>Sarah A. Fritz</b>		4. DATE OF DEATH <b>Nov 29 1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>OCT 19-1866</b>
9. AGE (In years last birthday) <b>90</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Charles A. Fritz</b>		Address <b>1301 HINDEN AVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic cardiovascular disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>approx 10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. s. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 1956</b> , to <b>Nov 29 1956</b> , that I last saw the deceased alive on <b>Nov 19 1956</b> , and that death occurred at <b>5:35 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert J. Leivickas</b> M.D.		ADDRESS (Street, city or town, state) <b>2436 Washington Blvd Baltimore - 30, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Herbert J. Leivickas</b>		DATE SIGNED <b>11/30/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>DEC 3-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROUSSEAU PARK</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Toulson</b>		24a. REC'D BY REGISTRAR <b>DEC 2 1956</b>	24b. REGISTRAR'S SIGNATURE <b>P. E. Barry</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NO 1 1976

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1097 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12140

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>about 20 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2972 Cornwall Rd.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>2972 Cornwall Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF <b>HATTIE</b> (Type or print) First <b>Hattie (Hedwig)</b> Middle <b>Funk</b> Last <b>Funk</b>				4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>19 56</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 1, 1902</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b></b>				14. MOTHER'S MAIDEN NAME <b></b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Lena Darr</b> Address <b>21 E.D. Brunswick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO <b></b> (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b></b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b></b> p. m. <b></b> 19 <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b> (County) <b></b> (State) <b></b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M. B. Darr</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/4/56</b>			
EXAMINER'S NAME (Type) <b>M. B. DARR</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Dec. 5, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) <b>Lovettsville, Virginia</b> (State) <b></b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home</b> ADDRESS <b>4210 Belair Rd. Balto.</b>				24a. REC'D BY REGISTRAR <b>DEC 7 1956</b> DATE <b></b>		24b. REGISTRAR'S SIGNATURE <b></b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

NO 1056

1056 V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11043

## CERTIFICATE OF DEATH

Reg. Dist. No. 11019

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>119 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bridgeville</b>	
		d. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>G</b> Last <b>GALANTE</b>		4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/19/26</b>
9. AGE (In years last birthday) <b>30</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Shop</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CORINO</b>		14. MOTHER'S MAIDEN NAME <b>SPLENDORA PALOME</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO <b>215-20-0075</b>	
17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NEURO SARCOMA</b> <b>193X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>VON RECKBURGHUSEN'S DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 29</b> , 19 <b>56</b> , to <b>November 25</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>November 25</b> , 19 <b>56</b> , and that death occurred at <b>5:20 A.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Constantine J. Papastreat</b> M.D.		ADDRESS (Street, city or town, state) <b>Veterans Administration Hospital</b> DATE SIGNED <b>11/25/56</b>	
PRINT NAME (Type) <b>CONSTANTINE J. PAPASTREAT, M.D.</b>		<b>Fort Howard, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11/25/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bridgeville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bridgeville, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HARDESTY FUNERAL HOME, BRIDGEVILLE, DELAWARE</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
		24b. REGISTRAR'S SIGNATURE <b>Newton L. Haskins</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A OVER 2

356

## 11044 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>105 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1155 Washington Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>A.</b> Last <b>GILLINGHAM</b>				4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/3/13</b>	
9. AGE (In years last birthday) <b>43 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assembler Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Copper Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William G. Gillingham</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Forbinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII</b>				16. SOCIAL SECURITY NO. <b>213-20-3450</b>		17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital. Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. <b>Meningitis, post operative</b> 2. <b>Urinary bladder stones</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>July 28</b> , 19 <b>56</b> , to <b>November 10</b> , 19 <b>56</b> , and that death occurred at <b>9:55 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Constantine J. Papastrat, M.D.</b> <b>Veterans Administration Hospital 11/10/56</b>							
PHYSICIAN'S NAME (Type) <b>CONSTANTINE J. PAPASTRAT, M.D.</b> <b>Fort Howard, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-12-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc.</b> <b>Wm Cook-Blight Funeral Home, Inc. 6009 Harford Rd.</b> <b>Baltimore, Md.</b>				24a. REC'D BY REGISTRAR <b>Nov 15, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Garber</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 16 1956

BUREAU V. A.

RECEIVED

## 10984 CERTIFICATE OF DEATH

Reg. Dist. No.

4r

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. LENGTH OF STAY IN 1b <b>20 Yrs.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1208 Francis Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lambert Rumsey Gittings</b>		4. DATE OF DEATH Month Day Year <b>November 7, 1956</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Aug. 11, 1885</b>		9. AGE (In years last birthday) <b>71</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Used Car</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>John R. Gittings</b>		14. MOTHER'S MAIDEN NAME <b>Emma Clarey</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John A. Gittings</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>General Arteriosclerosis</b> DUE TO (c) <b>Myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from <b>May 1944</b> , to <b>Nov 8, 1956</b> , that I last saw the deceased alive on <b>Nov 9, 1956</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>B B Brumbaugh</b>		M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 10, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	
22d. LOCATION (City, town, or county) <b>Baltimore Maryland</b>		22e. FUNERAL DIRECTOR'S SIGNATURE <b>Amber Inc 1329 Sulphur Sp. Rd.</b>		22f. ADDRESS		24a. REC'D BY REGISTRAR <b>Dr. Geo M. Ruffey</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

11045

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b <b>67 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>625 E St.</b>		d. STREET ADDRESS <b>625 E. Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>W.</b> Last <b>GLADFELTER</b>		4. DATE OF DEATH Month <b>Nov. 11,</b> Day <b>19</b> Year <b>56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14, 1874</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	IF UNDER 24 HRS Months <b></b> Days <b></b> Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Weir</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hess</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs. Bertha Deardorff</b>		Address <b>625 E. St. --19</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia - Hypostatic</b> <b>100.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis - Gen.</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 1, 1956</b> to <b>Nov 11, 1956</b> , that I last saw the deceased alive on <b>Nov 11, 1956</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R G Wildsior</b>		ADDRESS (Street, city or town, state) <b>520 D St. SpR 19</b>	
PHYSICIAN'S NAME (Type) <b>R G Wildsior</b>		DATE SIGNED <b>11.12</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 14, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	22d. LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Av.</b>		24a. READ BY REGISTRAR <b>Nov. 15, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Dwison L. L. L.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jatonsville</u>				c. LENGTH OF STAY IN 1b <u>5 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>305 Ingleside Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Lines</u>				d. STREET ADDRESS <u>Jatonsville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Label</u> Middle <u>B.</u> Last <u>Glaser</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1892</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>George Baker</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mrs. J.D. Collins 305 Ingleside</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cronax Thrombosis</u> DUE TO (c) <u>Arterio Sclerosis general</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>24 hrs</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Dehydration</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1950</u> to <u>Nov 30, 1956</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>56</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4605 Edmonson Ave.</u> DATE SIGNED <u>11/1/56</u>							
ACTUAL SIGNATURE <u>Cliff Ratliff Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		<u>4605 EDMONSON AVE.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Northwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Funeral Home - Cantonville, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 1 1956</u>		24b. REGISTRAR'S SIGNATURE <u>F. E. Harrys</u>	

BUREAU V. S.

DEC 4 1956

RECEIVED

## 11047 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Balto Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonoville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonoville md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>5516 Old Frederick Rd</u>		d. STREET ADDRESS <u>(Same)</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Agnes Graber</u> First Middle Last		4. DATE OF DEATH <u>11/13/56</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 5, 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles H. Graber</u>		14. MOTHER'S MAIDEN NAME <u>Sterner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wm. V. Graber</u> Address <u>(Same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerotic C-V Disease</u> DUE TO (c) <u>Senile Changes</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/20</u> 19 <u>55</u> to <u>11/13</u> 19 <u>56</u> , that I last saw the deceased alive on <u>11/13</u> 19 <u>56</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Victor F. Zing</u> M.D. <u>Catonoville, Md</u>		DATE SIGNED <u>11/14/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/16/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Catharist</u>	22d. LOCATION (City, town, or county) (State) <u>Balto md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Macnab &amp; Son</u> ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>11/17/56</u>	24b. REGISTRAR'S SIGNATURE <u>V.E. Harvey</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

10V - 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

. 11048 CERTIFICATE OF DEATH

11025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City (30)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>1528 Clarkson St</b>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Russel</b> Last <b>Gregory</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-17-1888</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer (SA)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Mfg.</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. City</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur O. Gregory</b>		14. MOTHER'S MAIDEN NAME <b>Emma E. Glass</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-05-4443</b>	
17. INFORMANT <b>Hospital records, Mt. Wilson State Hosp.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>far Advanced Pulmonary TB</b> DUE TO <b>with a large cavity in it upper lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Partial heart block. Myocardial damage.</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0. 31.</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-13-1956</b> to <b>11-17-1956</b> , that I last saw the deceased alive on <b>11-17-1956</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>11-17-1956</b>	
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		DATE SIGNED <b>11-17-1956</b>	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		<b>Mt. Wilson, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 21-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Howard Evans</b>		24. REG'D BY REGISTRAR <b>11-17-1956</b>	
ADDRESS <b>1400 S. Charles St - Balto 30 Md</b>		24b. REGISTRAR'S SIGNATURE <b>Sorothy Newcomb</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be filled with the funeral director's name and address. Page 2 should be filled with the funeral director's name and address. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

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BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

STREET ADDRESS

(If rural give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE OF DEATH:

(Month)

(Day)

(Year)

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

## 8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1956, to 1956, that I last saw the deceased

alive on 11/11/56, 1956, and that death occurred at 11/11/56, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BUREAU K. 2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

# MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## 11050 CERTIFICATE OF DEATH

110273

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Md.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood St. Tr. School</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 6, Maryland</b> d. STREET ADDRESS <b>1809 O'Dell Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lois</b> Middle <b>Carolyn</b> Last <b>Habicht</b>				4. DATE OF DEATH Month <b>November</b> Day <b>23rd</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/12/45</b>	
9. AGE (In years last birthday) <b>11</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Milton William Habicht</b>				14. MOTHER'S MAIDEN NAME <b>Alice Rebecca Deskins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Rosewood Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia - static</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cardiac failure</b> DUE TO (c) <b>Cachexia secondary to malnutrition due to severe retardation</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>and spastic paraplegia</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/23</b> , 19 <b>56</b> , to <b>11/23/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11/23/</b> , 19 <b>56</b> , and that death occurred at <b>11:30 A.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter T. Chen</b> M.D.				ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Walter T. Chen, M. D.</b>				DATE SIGNED <b>11/23/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Nov 26-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Morland Mausoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Taylor ave / Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Almond G. Hunt</b>				ADDRESS <b>Baltimore Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 11-26-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary Ellen</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11028

Reg. Dist. No.

10985

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>		c. LENGTH OF STAY IN 1b <b>4 yrs. plus</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore / Miss Alice Ekas</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Relay Hill Hospital</b>			d. STREET ADDRESS <b>c/o 4231 Euclid Avenue Baltimore, Md.</b>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
3. NAME OF DECEASED (Type or print) <b>Sadie</b> First Middle Last <b>Hackett</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>16,</b> Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1873</b>	9. AGE (in years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>William Wondrly</b>		
14. MOTHER'S MAIDEN NAME <b>Caroline --</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>4231 Euclid A venue</b> <b>Miss Alice Ekas: Longwood 6-8886</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Urinary tract infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Fracture left femour intertrahantiric</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Patient fell to floor on smooth surface</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>10-19-56</b> 19 p. m. <b>x</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>	20f. (City or town) (County) (State) <b>Relay, Baltimore Co., Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i>		M.D. <b>Geo. S. M. Kieffer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>Nov. 16, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 19/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Louden Park</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry H. White</i>		ADDRESS <b>4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <i>Dr. Geo. S. M. Kieffer</i>	
24b. REGISTRAR'S SIGNATURE					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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RECORDS



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11051

## CERTIFICATE OF DEATH

11029

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
c. LENGTH OF STAY IN 1b <b>68 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>11434 Holbrook Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>LEE</b> Last <b>HAMBURG</b>		4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1894</b>
9. AGE (In years to birthday) yrs <b>62</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman (Laborer)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Highway Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Hamburg</b>		14. MOTHER'S MAIDEN NAME <b>Nannie Jacobs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMPHYSEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNDIAGNOSED PULMONARY MASS - Duration unknown. Exploratory Thoracotomy 10-25-56</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 25, 1956</b> , to <b>November 1, 1956</b> , and that death occurred at <b>4:50 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>11/1/56</b>			
ACTUAL SIGNATURE <b>Joseph M. Miller</b> M.D.			
PHYSICIAN'S NAME (Type) <b>JOSEPH M. MILLER, M.D., Chief Surgical Service, VAH, Fort Howard, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-5-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b> ADDRESS <b>6009 Harford Rd., Balto. 14, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Harmon L. Parkers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11052

## CERTIFICATE OF DEATH

11030

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Howard</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
c. LENGTH OF STAY IN 1b <u>337 Days</u>		d. STREET ADDRESS <u>Riverside Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>(NMI)</u> Last <u>HARTUNG</u>		4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/14/81</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture Company</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Hartung</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Helfrich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service) <u>SPA</u>		16. SOCIAL SECURITY NO. <u>212 03 3872</u>	
17. INFORMANT <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CIRRHOSIS OF THE LIVER. EFF. IT S, CH. IIC, ARTERIOSCLER. TIC HEART</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>DISEASE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>7A</u> 19 <u>56</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 1, 1955</u> , to <u>November 2, 1956</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. T. Papas, M.D.</u> M.D. <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u></u>	
PHYSICIAN'S NAME (Type) <u>G. J. CASAPANT, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov-6-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Ave. Balto, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wippert Funeral Home Balto. &amp; Monroe Sts. Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u>Danison L. Farley</u>	

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OCT 2 1956  
U. S. AIR FORCE



11031 30

## 11053 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.'s Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>419 Addison Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Effie Wingate Hastings</b>		4. DATE OF DEATH Month <b>November</b> Day <b>15</b> , Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1873</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>— AT HOME —</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Stern Wingate</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Ford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis</b>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 15, 1955</b> to <b>Nov. 15, 1956</b> , that I last saw the deceased alive on <b>Nov. 15, 1956</b> , and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D. <b>SPRING GROVE STATE HOSPITAL 11-15-56</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 17, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Addison Chapel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Seat Pleasant Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>		24a. REC'D BY REGISTRAR <b>191056</b>	
ADDRESS <b>60517-11<sup>th</sup> St SE Wash DC</b>		24b. REGISTRAR'S SIGNATURE <b>H. E. Berry</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. Page 5

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11032

## 10986 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus, Md.</u>				c. LENGTH OF STAY IN 1b <u>65 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maiden Choice Lane</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus, Md.</u>			
d. STREET ADDRESS <u>Maiden Choice Lane-29</u>				• IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>M</u> Last <u>Hastings</u>				4 DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>19 56</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>April 11-1891</u>	
9. AGE (In years last birthday) yrs. <u>65</u>		IF UNDER 1 YEAR Months <u>21</u> Days <u>21</u> Hours <u>19</u> Min. <u>56</u>		IF UNDER 24 HRS Months <u>21</u> Days <u>21</u> Hours <u>19</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred-rick Vollers</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Schaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>George Hastings</u> Address <u>Maiden Choice Lane.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Hypertensive Cardiac Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Drain</u> DUE TO (c) <u>Drain</u>				INTERVAL BETWEEN ONSET OF DEATH <u>9 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>Mar 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar 20</u> , 19 <u>56</u> , and that death occurred at <u>29</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert Scaggett</u> M.D.				ADDRESS (Street, city or town, state) <u>1729 W Lombard St</u>			
PHYSICIAN'S NAME (Type) <u>ALBERT Scaggett</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 24-56.</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Ave. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund Perry</u>				ADDRESS <u>5646 Carville Ave.</u>		24a. REC'D BY REGISTRAR <u>DATE 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Geo M. Kueffer</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FOLGATE</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7603 RIDDLE AVE</b>		d. STREET ADDRESS <b>7605 Riddle</b>	
3. NAME OF DECEASED (Type or print) <b>Archie</b> First Middle Last		4. DATE OF DEATH Month <b>Nov</b> Day <b>6</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 11, 1879</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labour Ret</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Don't Know</b>		14. MOTHER'S MAIDEN NAME <b>Don't Know</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <b>Marie Connor 501 Lawrence Ave</b>			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Jack C Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JACK C COLLINS</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Nov 9/56</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Balti Co</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Howard Home 2112 Dundalk Ave</b>		24a. REC'D BY REGISTRAR <b>Nov 1 1956</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Wm. Bell</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 45

11054

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>440 Whitethorn Way</u>		d. STREET ADDRESS <u>440 Whitethorn Way</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>John Lawrence Hedderman</u>		4. DATE OF DEATH Month Day Year <u>November 13, 19 56</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/1898</u>
9 AGE (In years last birthday) yrs <u>58</u>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Procurement Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Hedderman</u>	
14. MOTHER'S MAIDEN NAME <u>Unkown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>212-12-6367</u>		17. INFORMANT Address <u>Pearl May Hedderman Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of bladder</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stomach ulcer of jejunum</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/19/56</u> 19____, to <u>11/13/56</u> 19____, that I last saw the deceased alive on <u>11/12/56</u> 19____, and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph H. Vical</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>423 Eastern Ave 11/13/56</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH VICAL</u>		<u>Ernest 21 Ind</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/16/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Brudzinski</u>		ADDRESS <u>107 W. 1st Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>11/13/56</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hueley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11055 CERTIFICATE OF DEATH

11035 30

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <b>Ind</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>33 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>609 Cedarhurst Road</b>		e. STREET ADDRESS <b>609 Cedarhurst Road</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>HELLEN</b> Middle <b>LAST</b>		4. DATE OF DEATH <b>NOV-27</b> Month <b>Nov</b> Day <b>27</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 19, 1880</b>
9. AGE (In years last birthday) <b>76</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ind. Trust</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hellen</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Bingham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>61714-5523</b>	
17. INFORMANT <b>Carrie M. Hellen</b> Address <b>609 Cedarhurst Rd #9</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>14201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic C.V.D.</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1953, 1956</b> to <b>11/27, 1956</b> , that I last saw the deceased alive on <b>11/2, 1956</b> , and that death occurred at <b>E.A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. C. Pounds</b> M.D. <b>3225 Frederick Ave</b>		DATE SIGNED <b>10/27/56</b>	
PHYSICIAN'S NAME (Type) <b>J. C. Pounds</b>		<b>BALTO. Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>Nov 30, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Westminster</b>	22d. LOCATION (City, town, or county) (State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Gipe</b> ADDRESS <b>5311 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>11/27/56</b>	24b. REGISTRAR'S SIGNATURE <b>V. E. Perry</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**11056** CERTIFICATE OF DEATHReg. Dist. No. **43** ...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Baltimore-rural</u>				TOWN <u>Baltimore-rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 190-Route 16-Bird River Rd.</u>				STREET ADDRESS (If rural give location) <u>Box 190-Route 16-Bird River Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>John F. Heine</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Nov. 22 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>June 6, 1894</u>	
9. AGE last birthday <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At Home</u>		11. BIRTHPLACE (State or foreign country): <u>Balta. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Mr. Heine</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-01-4155</u>		17. INFORMANT & ADDRESS: <u>Daniel J. Heine Sr. - 605 N. Curley St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Broncho-pneumonia</u>				<u>7 days</u>			
ANTECEDENT CAUSE (S) (B) <u>Multiple cerebral</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Thrombosed</u>				<u>18 months</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July, 1953</u> to <u>Nov 22, 1956</u> , that I last saw the deceased alive on <u>Nov 22, 1956</u> , and that death occurred at <u>9408 N. Taylor</u> M. D. from the causes and on the date stated above.							
SIGNATURE <u>Joseph M. H. H. H.</u>		ADDRESS <u>108 S. Taylor</u> DATE SIGNED <u>11/23/56</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-26-56</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Balta. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>December 24, 1956</u>		REGISTRAR'S SIGNATURE <u>R. W.</u>		24. FUNERAL DIRECTOR <u>John C. Miller Inc.</u>		ADDRESS <u>243 S. E. Oliver St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11057 CERTIFICATE OF DEATH

11037 37

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1652 Shadyside Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>P.</b> Last <b>HESSINGER</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>29</b> Year <b>19 56</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 7, 1865</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Quartermaster's Dept. (Civilian) U.S. Govt</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Penna.</b>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Theodore Hessinger</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Engelkirk</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Edwin K. Clickner - 3426 - 16th St. N. W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mixed organism</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchitis, generalized arterio-sclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3/4/54</b> , 19____, to <b>present</b> , 19____, that I last saw the deceased alive on <b>11/29</b> , 19____, and that death occurred at <b>12:05 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ernest C. Brown</b> M.D.				ADDRESS (Street, city or town, state) <b>1101 N. Calvert St., Balt. Md.</b>			
DATE SIGNED <b>11/30/56</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/1/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Elkridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiskner &amp; Sons - Balt. Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>12/1/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Lois MacIntyre</b>			

UNITED STATES

1897

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11058

## CERTIFICATE OF DEATH

## 11038 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1835 Edgewood Road</u>				d. STREET ADDRESS <u>1835 Edgewood Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Miss Regina E. Hieber</u>				4. DATE OF DEATH <u>November 18th 1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 18, 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Worker, Comptometer</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Hieber</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Aufarth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mrs. Margaret Hieber, 1835 Edgewood Road.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>Metastatic breast carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 12, 1954</u> to <u>Nov 18, 1956</u> , that I last saw the deceased alive on <u>Nov 15, 1956</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert E. Gray</u>				ADDRESS (Street, city or town, state) <u>1200 Woodbourne Av. Balto 12 Md.</u>			
PHYSICIAN'S NAME (Type) <u></u>				DATE SIGNED <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/1/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Hargford Road.</u>			
24a. RECEIVED BY REGISTRAR <u></u>				24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>			
DATE <u>Nov. 19, 1956</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.



## MARYLAND STATE DEPARTMENT OF HEALTH

11039

2411 N. Charles Street, Baltimore

Dr. Gordon Grau:

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

11059

1. PLACE OF DEATH COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1777 Amuskai Rd.</u>		STREET ADDRESS (If rural, give location) <u>1777 Amuskai Road</u>	
3. NAME OF DECEASED (Type or Print) <u>CATHERINE M. HIGGINS</u>		4. DATE OF DEATH <u>11/17/56</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1907</u>
9. AGE last birthday <u>49</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Stores</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Willbur Rowe</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mr. M.H.Higgins-1777 Amuskai Rd.</u>			

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of Cervix

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>11/4/52</u>		19b. MAJOR FINDINGS OF OPERATION <u>Uterine cell carcinoma of cervix</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 6/1/52, 1952, to 11/17, 1956, that I last saw the deceasedalive on 11/17, 1956, and that death occurred at 11/17, 1956, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11/21/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto.</u>	
DATE RECD BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>WIEDEFELD &amp; SON</u>		ADDRESS <u>GREENMOUNT AVE &amp; 22ND</u>	

MARGIN RESERVED FOR FILING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11040

CERTIFICATE OF DEATH

Reg. Dist. No.

31

11069

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belleville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				d. STREET ADDRESS <u>101 W. University Parkway</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Adele</u> Middle <u>Thomas</u> Last <u>Hilgartner</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1871</u>	9. AGE (In years last birthday) <u>85</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Philip Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Not obtainable</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <u>Mrs. Edwin F. Hoffmaster</u>				Address <u>2920 Ardmore Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA—UTERUS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>2 JUNE, 1947</u> to <u>27 NOV, 1956</u> , that I last saw the deceased alive on <u>26 Nov, 1956</u> , and that death occurred at <u>5 P M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John B. De Hoff</u>				ADDRESS (Street, city or town, state) <u>2020 K Charles St</u>			
PHYSICIAN'S NAME (Type) <u>John B. De Hoff</u>				DATE SIGNED <u>Baltimore 18, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. T. ... Son</u>				ADDRESS <u>8-5 N. ... Street</u>		24a. REC'D BY REGISTRAR DATE <u>11/23/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Gene MacRae</u>							

U. S. A.

100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11041

11061

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1 PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>20 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1404 Mountmor Court</b>			
3 NAME OF DECEASED (Type or print) First <b>CHRISTOPHER</b> Middle <b>(NMI)</b> Last <b>HILL</b>				4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/15/38</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>N U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>MARY ELLEN (MN: UNKNOWN)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or date of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>212-01-2766</b>		17. INFORMANT Address <b>Clin.Rec.Vets.Admin.Hospital,Ft.Howard,Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC BRAIN SYNDROME</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>Senile arteriosclerotic nephrosclerosis</b> (b) <b>Stricture of urethra</b> (c) <b>Arteriosclerotic cardiovascular disease</b> (d) <b>Chronic cystitis</b> (e) <b>Leukoplakia of</b>							
19. WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 21, 1956</b> , to <b>November 10, 1956</b> , and that death occurred at <b>12:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Caridad E. Gonzalez M.D.</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>Veterans Administration Hospital 11/11/56</b>			
PHYSICIAN'S NAME (Type) <b>CARIDAD GONZALEZ, M.D.</b>				Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/14/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law, Mortuary, 802-04 Madison Ave., Balto. Md.</b>				24a. REC'D BY REGISTRAR <b>141956</b>			
				24b. REGISTRAR'S SIGNATURE <b>Samuel L. Larky</b>			

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## 11062 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1204 Culvert Road</i>		d. STREET ADDRESS <i>1204 Culvert Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Mr. Charles</i> Middle <i>J.</i> Last <i>Holthaus</i>		4. DATE OF DEATH Month <i>November</i> Day <i>5</i> Year <i>1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 22, 1896</i>
9. AGE (In years lost birthday) <i>59</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tallyman, (Ship)</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Frederick Holthaus</i>		14. MOTHER'S MAIDEN NAME <i>Bridget Mc Call</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>217-09-5806</i>	
17. INFORMANT <i>Mrs. Helena Holthaus, 1204 Culvert Rd.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Decompensative Cardiovascular Disease</i> DUE TO (b) <i>Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1</i> , 19 <i>56</i> to <i>Nov. 5</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Nov. 5</i> , 19 <i>56</i> , and that death occurred at <i>7:15 P.</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lawrence C. Post</i>		DATE SIGNED <i>6105 York Rd. Baltimore 12 Md 11/6/56</i>	
PHYSICIAN'S NAME (Type) <i>LAWRENCE C. POST</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/8/1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. RECEIVED BY REGISTRAR <i>Nov. 7, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. Page 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

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11063

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>			
c. LENGTH OF STAY in lb <u>33 yrs</u>				d. STREET ADDRESS <u>113 Rosewood Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home in Pine Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eleanor</u> First <u>Hoopnagle</u> Middle <u>Hoopnagle</u> Last				4. DATE OF DEATH <u>11/14/56</u> Month <u>11</u> Day <u>14</u> Year <u>19</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/3/1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>			
13. FATHER'S NAME <u>William Hoopnagle</u>				14. MOTHER'S MAIDEN NAME <u>Owings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Dr. Robert E. Hoopnagle</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertension Cordis Trunculi-Renal Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>15 yrs (?)</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-14</u> 19 <u>49</u> , to <u>11-14</u> 19 <u>56</u> , that I last saw the deceased alive on <u>11-13</u> 19 <u>56</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u>Bald. 28, Md.</u>							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>				M.D. <u>6209 Frederick Ave.</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				ADDRESS <u>Bald. 28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McNabb &amp; Son</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR DATE <u>11/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>T.E. Harry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 19 1956

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## 10972 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u> MARYLAND		STATE <u>MD</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK</u>		LENGTH OF STAY (in this place) <u>3 YRS</u>		STREET ADDRESS <u>1922 AUGUST AVE</u>		STREET ADDRESS (If rural, give location) <u>1922 AUGUST AVE</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>BENNETT ERIC HUBBARD</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>NOV. 3 1956</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>MARRIED</u>		8. DATE OF BIRTH: <u>AUG. 17, 1903</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE FITTER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>AMERICAN SMELTING</u>		9. AGE last birthday: <u>53</u> yrs.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>SAMUEL HUBBARD</u>				14. MOTHER'S MAIDEN NAME: <u>MARY PINDELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY No.: <u>212-10-2102</u>			
17. INFORMANT & ADDRESS: <u>CLARA M. HUBBARD 1925 AUGUST AVE</u>				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
180X Immediate cause (a) <u>Generalized metastasis of left kidney</u>				11 mos			
Antecedent cause(s) (b) <u>of left kidney</u>				1 from history			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>Nov 31 1955</u>				19b. MAJOR FINDINGS OF OPERATION: <u>Malignancy 7 Kidney</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		CITY OR TOWN		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>me</u> , 19 <u>56</u> , to <u>Nov 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 3</u> , 19 <u>56</u> , and that death occurred at <u>11:45 AM.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. E. R. R. R.</u>				DATE SIGNED <u>11/3/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>NOV. 6-56</u>		NAME OF CEMETERY OR CREMATORY <u>BALTO. CEM.</u>		LOCATION (City, town, or county) (State) <u>E. NORTH AVE BALTO. MD</u>	
DATE RECD BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS <u>W. J. Bros 1800 E. LOMBARD ST</u>			

MARGIN RESERVED FOR BINDING

VS. A15 851

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11064

## CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2mth 1 dy.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. STREET ADDRESS <b>3719 W. Garrison</b> <b>4007/FAARWOOD AVENUE</b>			
3. NAME OF DECEASED (Type or print) <b>Mollie Rebecca Huber</b>				4. DATE OF DEATH <b>Nov. 25</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1881</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>dressmaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Huber</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth DeBus</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>216-10-8632</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chloropromazine jaundice</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Sept. 25, 1956</b> , to <b>Nov. 25, 1956</b> , that I last saw the deceased alive on <b>Nov. 25, 1956</b> , and that death occurred at <b>4:30 p. m.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D.				DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 11-26-56</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				ADDRESS (Street, city or town, state) <b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/28/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balt. 17, Md.</b>				24a. REC'D BY REGISTRAR <b>Nov. 28, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>A. E. Harvey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then all pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 9 1956

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## 11065 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Providence</b>		c. LENGTH OF STAY IN 1b <b>Providence</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Providence Road</b>		d. STREET ADDRESS <b>Providence Road</b>	
3 NAME OF DECEASED (Type or print) <b>ALEXANDER ISAAC WAYNE JACKSON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>16</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1894</b>
9 AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Baker—retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>A. I. Wayne Jackson</b>	
14. MOTHER'S MAIDEN NAME <b>Catherine Kemp</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO YES</b>	
16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>Family Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage with right hemiplegia</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>Unknown</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May</b> , 1952, to <b>Nov 16</b> , 1956, that I last saw the deceased alive on <b>Nov 16</b> , 1956, and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Rollin C. Hudson</b>		ADDRESS (Street, city or town, state) <b>606 Baltimore Ave Towson Md 118156</b>	
PHYSICIAN'S NAME (Type) <b>Rollin C. Hudson</b>		DATE SIGNED <b>11/18/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 29, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Merie Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Towson, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns</b>		ADDRESS <b>Towson, Maryland</b>	
24a. REC'D BY REGISTRAR <b>11/19/56</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

11047

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>85 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>James</u> Last <u>James</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>62 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Praybiter &amp; Smith, M.D. Sp. Hosp.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiovascular disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic alcoholism</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 27</u> , 19 <u>56</u> , to <u>Nov. 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 17</u> , 19 <u>56</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Ward</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove Hosp - 11/18/56</u>	
PHYSICIAN'S NAME (Type) <u>DR. CHARLES WARD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/21/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. Denny, Inc</u> ADDRESS <u>75 LIGHT ST</u>		24a. REC'D BY REGISTRAR <u>DATE 11-21-56</u>	24b. REGISTRAR'S SIGNATURE <u>Victor C. Harry</u>

7

1956

1956

1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 2, Filed 11/23/56 bh

## CERTIFICATE OF DEATH

11067

Reg. Dist. No.

11048

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Douglas Memorial Church Home</b>				d. STREET ADDRESS <b>Frederick Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>ROSE</b> First <b>G.</b> Middle <b>JAMES</b> Last		4. DATE OF DEATH <b>Nov. 14, 1956</b> 19		Month		Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Widow</b> <b>Unknown</b> <b>Divorced</b> <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 14, 1900</b>	9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unk.</b>				14. MOTHER'S MAIDEN NAME <b>Unk.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown)		16. SOCIAL SECURITY NO. <b>hmc</b>		17. INFORMANT <b>Mrs. Corrine Bolling-Matron</b> <b>Douglas Memorial Church Home</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410X</b> <b>Mitral Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonitis (Virus Infection)</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>22 days</b> <b>10 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-23-56</b> , 19____, to <b>11-15-56</b> , 19____, that I last saw the deceased alive on <b>11-15-56</b> , 19____, and that death occurred at <b>11:30 A.M.</b> , from the causes and on the date stated above. <b>P.M.</b> ADDRESS (Street, city or town, state) DATE SIGNED <b>C. F. Maloney, M.D.</b> <b>57 Winters Lane, Balto. 28</b> <b>11/16/56</b>							
ACTUAL SIGNATURE <b>C. F. Maloney</b>		PHYSICIAN'S NAME (Type) <b>C. F. Maloney, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 17, '56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>1601 David Hill Ave</b>				24a. REC'D BY REGISTRAR <b>NOV 19 1956</b>		24b. REGISTRAR'S SIGNATURE <b>J. E. Harris</b>	

EDWARD A. B.

1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11049

11068

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>294 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>5503 Belair Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>J.</b> Last <b>JASPER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>19 56</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 12, 1889</b>	9. AGE (In years last birthday) yrs. <b>67</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Warehouseman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Distillery</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank Jasper</b>				14. MOTHER'S MAIDEN NAME <b>Wilhelmina Goeller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO <b>215-22-6692</b>		17. INFORMANT Address <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LEFT LUNG WITH METASTASIS TO THE CHEST WALL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>163X</b> (c) <b>163X</b> DUE TO							INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Diabetes mellitus 2. Generalized arteriosclerosis. 3. Above knee amputation, left. 4. Gangrene of the right big toe</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 7, 1956</b> , to <b>November 27, 1956</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>C. J. PAPASTRAT, M.D. M.D. VAH, FORT HOWARD, MARYLAND 11/28/56</b>							
ACTUAL SIGNATURE <b>C. J. PAPASTRAT, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-1-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>				24a. REC'D BY REGISTRAR <b>EC 3 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Newton L. Lurberg</b>	

S. A. OVERMAN

1914

CERTIFICATE OF DEATH

11050

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Lutheran Deaconess Home</b>		d. STREET ADDRESS <b>1100 Boyce Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Sophia First Middle Last</b> <b>SOPHIA JEPSON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov: 12, 1861</b>
9. AGE (In years last birthday) <b>95</b> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deaconess</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lutheran Home</b>	11. BIRTHPLACE (State or foreign country) <b>Denmark</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>Jens Sorrensen</b>	
14. MOTHER'S MAIDEN NAME <b>Anna Nielsen</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Records Lutheran Home</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-29, 1956</b> , to <b>11-30, 1956</b> , that I last saw the deceased alive on <b>11-29, 1956</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. L. Ewald</b>		DATE SIGNED <b>36 YORK COURT 12-1-56</b>	
PHYSICIAN'S NAME (Type) <b>A. L. EWALD JR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec: 3, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Hippen</b>		24a. REC'D BY REGISTRAR <b>1300 Eutaw Place</b>	24b. REGISTRAR'S SIGNATURE <b>12/6/56</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 A CVER

908

DEALERS



11070

## CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH a. COUNTY <b>Sweet Air Balto., Co., MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b <b>10 yrs.</b>				<b>Sweet Air, Balto. Co., Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Sweet Air</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Myrtle Augusta Jessop</b>				4. DATE OF DEATH Month Day Year <b>Nov. 20 19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 4, 1898</b>	
9. AGE (In years last birthday) <b>58 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>James R. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Lotta Cunningham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Stewart M. Jessop Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Hypertensive Cardiovascular Dis</b> DUE TO (c) <b>16.9.56</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>July 11, 19 51</b> to <b>Nov. 20, 19 56</b> , that I last saw the deceased alive on <b>Nov. 20, 19 56</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>FORK, MD.</b> DATE SIGNED ACTUAL SIGNATURE <b>CLIFFORD F. HUDSON</b> PHYSICIAN'S NAME (Type) <b>CLIFFORD F. HUDSON</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-23-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chesnut Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Sweet Air, Balto., Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. L. Jenkins &amp; Son, 4905 York Rd.</b>				24a. REC'D BY REGISTRAR DATE <b>11-23-56</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth Gorsuch</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, 3-12 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 11052

11071

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>RASPEBURG</u>	STATE <u>Md.</u> COUNTY <u>BALTIMORE</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>RASPEBURG</u>
TOWN <u>RASPEBURG</u>	LENGTH OF STAY (in this place) <u>50 yrs</u>	STREET ADDRESS (If rural give location) <u>292 Ridge Rd BALTO.</u>	OR TOWN <u>RASPEBURG</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
<u>LAURA I. JOHNSON</u>		<u>11 - 11 1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>WIDOW</u>	8. DATE OF BIRTH: <u>5-16-1876</u>
9. AGE last birthday <u>80</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>HENRY PRESCOE</u>		14. MOTHER'S MAIDEN NAME: <u>MARY WILLIAMS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>WESLEY P. JOHNSON</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE <u>Congestive Heart Failure</u>			<u>2 weeks</u>
(B) ANTECEDENT CAUSE (S) <u>Arteriosclerotic Cardiovascular Disease</u>			
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Simian</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>October, 1956</u> , to <u>November 19, 1956</u> , that I last saw the deceased alive on <u>Oct. 30, 1956</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>A. Andrew Alece</u>		DATE SIGNED <u>11/12/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-14-56</u>	
NAME OF CEMETERY OR CREMATORY <u>POTTY HILL</u>		LOCATION (City, town, or county) (State) <u>BALTO. County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/13/56</u>		24. FUNERAL DIRECTOR, ADDRESS <u>Joseph B. Locke, Jr. 1304 N. Central Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 11072 CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>132 Lincoln Ave.</b>		d. STREET ADDRESS <b>132 Lincoln Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM HENRY JONES Jr.</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2,</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1875</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home-caretaker</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Jones, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Emma Jones</b>		Address <b>132 Lincoln Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <b>1</b> p. m. Month, Day, Year <b>1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/1/53</b> to <b>7/1/56</b> , that I last saw the deceased alive on <b>7/1/56</b> , and that death occurred at <b>6:10 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>11/4/56</b>			
ACTUAL SIGNATURE <b>Bennett A. Stoen</b>			
PHYSICIAN'S NAME (Type) <b>Bennett A. Stoen</b> Signed at Request of M.F.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 6, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Rest</b>		22d. LOCATION (City, town, or county) (State) <b>Towson, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Funeral Home</b>		24a. REC'D BY REGISTRAR <b>Nov. 5, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Thane MacRae</b>			

BUREAU V. S.

NOV 5 1936

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 1-1-60

## CERTIFICATE OF DEATH

11054

Reg. Dist. No.

11073

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1122 Arran Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Raymond</b> Last <b>Kapp</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7 1883</b>
9. AGE (In years last birthday) <b>72 73</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rail road Engineer ret</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Isreal S Kapp</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>C Raymond Kapp</b>		Address <b>1122 Arran Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>56</b> , to <b>November</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov 26</b> , 19 <b>56</b> , and that death occurred at <b>2:30 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. F. Palmisano</b> M.D.		ADDRESS (Street, city or town, state) <b>6014 Loch Raven Blvd Baltimore 12, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. F. PALMISANO M.D.</b>		DATE SIGNED <b>11/29/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Nov 30/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home</b>		ADDRESS <b>4210 Belair Road</b>	
24a. REC'D BY REGISTRAR <b>NOV 29 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Malik Gray</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956

21

RECEIVED



11074

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
c. LENGTH OF STAY IN 1b <u>Editone</u>				d. STREET ADDRESS <u>14 Walker Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>— 14 Walker Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anna M. Kence</u>			4. DATE OF DEATH <u>Nov 28 1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9 1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Josiah Sapp</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Knight</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Arthur C. Kelly</u>		Address <u>Bally, 17 Md. 225 Dundalk Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Pneumonia</u>							<u>1 mo.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u>							<u>5 years.</u>
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>30 Nov 1953</u> , to <u>28 Nov 1956</u> , that I last saw the deceased alive on <u>27 Nov 1956</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H Rouse</u>				ADDRESS (Street, city or town, state) <u>908 Reisterstown Rd</u>			
PHYSICIAN'S NAME (Type) <u>Paul H Rouse MD</u>				DATE SIGNED <u>28 Nov 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov 30 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wood Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u>				ADDRESS <u>Pikesville</u>		24. REC'D BY REGISTRAR <u>REC 3</u>	
				24b. REGISTRAR'S SIGNATURE <u>Anthony Muelis</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF

CHICAGO

LIBRARY

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKVILLE</b>	
c. LENGTH OF STAY IN 1b <b>32 years</b>		d. STREET ADDRESS <b>2948 Edgewood Ave</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2948 Edgewood Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>M.</b> Middle <b>Keller</b> Last		4. DATE OF DEATH <b>Nov 4 1956</b> Month <b>Nov</b> Day <b>4</b> Year <b>1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 21-1884</b> 72 yrs.
9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Koss</b>		14. MOTHER'S MAIDEN NAME <b>MARY Andre</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary Knepper</b> Address <b>2948 Edgewood Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Stroke / massive Silent Coronary Thromb</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hypert. Arteriosclerotic. Card. Vasc. Dis.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hour</b> <b>7+ yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>Nov</b> Day <b>4</b> Year <b>1956</b> Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1</b> , 1956, to <b>Nov 4</b> , 1956, that I last saw the deceased alive on <b>Nov 4</b> , 1956, and that death occurred at <b>3:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank T. Kasik Jr.</b> M.D.		DATE SIGNED <b>11/4/56</b>	
PHYSICIAN'S NAME (Type) <b>FRANK T. KASIK JR. M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Nov. 7 - 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas F Evanson Sm</b> ADDRESS <b>8802 Hartford Rd</b>		24a. REC'D BY REGISTRAR <b>Nov 5 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Dr. A. M. Bacon</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11076

## CERTIFICATE OF DEATH

11057

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>18 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Company from State Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Clunie</u> Middle Last <u>Kendall</u>		4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Allen MacDonald</u>		14. MOTHER'S MAIDEN NAME <u>Marjorie Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sp. to Hosp.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conjunctive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Embolism - Paradoxical</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 27, 1938</u> to <u>Nov. 17, 1956</u> that I last saw the deceased alive on <u>Nov. 17, 1956</u> and that death occurred at <u>11:40 P.M.</u> from the causes and on the date stated above.			
DECEASED'S SIGNATURE <u>Charles Ward</u> M.D.		DATE SIGNED <u>Spring Grove Hosp - 11/18/56</u>	
PHYSICIAN'S NAME (Type) <u>DR. CHARLES WARD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-21-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE 11-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>Victor C. Harry</u>	

1056

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11077

## CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> <u>Life</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5429 Whitlock Rd</u>				d. STREET ADDRESS <u>5429 Whitlock Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <u>EDWARD</u> (Type or print) First Middle Last <u>Edward</u> <u>A.</u> <u>Kernan Sr.</u>				4. DATE OF DEATH Month Day Year <u>Nov.</u> <u>6</u> <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1902</u>		9. AGE (In years last birthday) <u>54</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John J. Kernan</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Caten</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Edna M. Kernan, 5429 Whitlock Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombocytopenia Purpurea</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/4 hour</u> <u>2 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Splenectomy 2 yrs ago.</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>ch</u>		20f. (City or town) (County) (State) <u>ch</u>	
21. I certify that I attended the deceased from <u>Aug.</u> , <u>1954</u> , to <u>Nov. 6</u> , <u>1956</u> , that I last saw the deceased alive on <u>Nov. 6</u> , <u>1956</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>M. J. McDermott</u> M.D. <u>11/8/56</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>				ADDRESS <u>4101 Edmondson Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>11/13/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. E. Harry</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 19 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11078 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11059 43

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore #6</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1014 SUMTER</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Harry</u> Last <u>KERR</u>				4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 21-1940</u>		9. AGE (In years last birthday) <u>16</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>High-school</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John D. KERR</u>				14. MOTHER'S MAIDEN NAME <u>Brauchmeyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219 36 1701</u>		17. INFORMANT <u>PARENTS</u> Address <u>(same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRANsection of Torso - Multiple</u> <u>902X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushing injuries - Struck</u> DUE TO (c) <u>by TRAIN</u> INTERVAL BETWEEN ONSET AND DEATH <u>INSTANTANEOUS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>9:30 a.m.</u> <u>11-8</u> <u>1956</u>		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RR track</u>		20f. City or town <u>Baltimore</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack C Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 10-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly, Essex, Md.</u>				24a. REC'D BY REGISTRAR <u>11-8-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mo. A. L. Perforendy</u>	

SECRET

NOV 1964

SECRET

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11060

11079

## CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Falls</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Falls</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Upper Falls</u>		d. STREET ADDRESS <u>Upper Falls</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CAROLINE</u> <u>BLANCHE</u> <u>KEYSER</u>		4. DATE OF DEATH Month Day Year <u>Nov.</u> <u>1</u> <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 18 1864</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Beale Rumsey</u>		14. MOTHER'S MAIDEN NAME <u>Frances H Evans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Matthew Howard Rumsey</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>400.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>20 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct.</u> <u>1955</u> to <u>Oct.</u> <u>1956</u> , that I last saw the deceased alive on <u>Oct. 15</u> <u>1956</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>Nov. 2, 1956</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 5, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Kingsville, Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Rd.</u>		24a. REC'D BY REGISTRAR <u>John Walter Karametis</u>	24b. REGISTRAR'S SIGNATURE <u>John Walter Karametis</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11080

## CERTIFICATE OF DEATH

11061

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BRIARSTONE RD.</u>				d. STREET ADDRESS <u>BRIARSTONE RD.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>EVELYN</u> <u>CONSIDINE</u> <u>KIRBY</u>				4. DATE OF DEATH Month Day Year <u>NOV.</u> <u>6</u> <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 6 - 1906</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME MAKER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN CONSIDINE</u>				14. MOTHER'S MAIDEN NAME <u>SADYEA SHIPLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-30-0524</u>		17. INFORMANT Address <u>MARTIN KIRBY BRIARSTONE RD RANDALLSTOWN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA BREAST &amp; METASTASIS</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>TO SPINE - CERVICAL &amp; THORACIC.</u> DUE TO (c) <u>5 YEARS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>APRIL 1, 1956</u> , to <u>NOV. 6, 1956</u> ; that I last saw the deceased alive on <u>NOV. 6, 1956</u> , and that death occurred at <u>9:10</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>3601 CHEWARR RD - BALTO 7 - MD.</u> <u>11/6/56</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>				<u>3601 CHEWARR RD - BALTO 7 - MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11/9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Sicker &amp; Sons - Balto 17, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Nov. 7, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. J. M. E. Martin</u>	

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U. S. BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>4 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE ST. HOSP</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MONKTON</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY CATHERINE KIRBY</b>		4. DATE OF DEATH Month Day Year <b>11 / 26 1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 / 21 / 1887</b>
9. AGE (In years lost birthday) <b>68 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILLIAM KIRBY</b>		14. MOTHER'S MAIDEN NAME <b>ANNA KIRBY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic obliterative pericarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Infarctive myocardial fibrosis</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 2, 1952</b> to <b>Nov. 26, 1956</b> , that I last saw the deceased alive on <b>Nov. 26, 1956</b> , and that death occurred at <b>9:57 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Isadore Tuerk, M. D. SPRING GROVE STATE HOSPITAL 11-27-56</b> Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-29-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. James</b>
22d. LOCATION (City, town, or county) (State) <b>Monkton MD</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Scott Brooks</b>	
24a. REC'D BY REGISTRAR DATE <b>11/29/56</b>		24b. REGISTRAR'S SIGNATURE <b>V.E. Harry</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM V. S.

101

RECEIVED



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Tlien please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 Film 207 11-19-56 et

11082 CERTIFICATE OF DEATH

11063

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rodgers Forge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rodgers Forge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>231 Dumbarton Rd.</b>				d. STREET ADDRESS <b>231 Dumbarton Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>M.</b> Last <b>KISER</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>7</b> Year <b>19 56</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 11, 1887</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>19</b> Min <b>56</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>-</b>			
13. FATHER'S NAME <b>John W. (last name unknown)</b>				14. MOTHER'S MAIDEN NAME <b>Mary Whitman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mr. LeRoy Kiser - 231 Dumbarton Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio Vascular Disease</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> DUE TO <b>-</b> (c) <b>-</b>						INTERVAL BETWEEN ONSET AND DEATH <b>-</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. j.</b> 19 p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>	
20f. (City or town) <b>-</b>				20g. (County) <b>-</b>		20h. (State) <b>-</b>	
21. I certify that I attended the deceased from <b>Nov 6</b> , 19 <b>56</b> , to <b>Nov 7</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov 7</b> , 19 <b>56</b> , and that death occurred at <b>6:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6805 York Rd. Baltimore 12, Md</b> DATE SIGNED <b>11-8-56</b>							
ACTUAL SIGNATURE <b>Laurence C. Post</b> M.D.				PHYSICIAN'S NAME (Type) <b>LAURENCE C. POST</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/10/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>	
22d. LOCATION (City, town, or county) <b>Elkridge, Md.</b>				22e. (State) <b>Md.</b>		22f. (County) <b>-</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto 17, Md.</b>				24a. REC'D BY REGISTRAR <b>Nov 13 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

1956

TO DE  
cute  
forw  
TO FILE

VS. A15ME1  
SM 9/35

**MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any  
"ale, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral  
o Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for ya.  
TOR: Page 3 should be read as in handwritten manner.

scenary, 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 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1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100. 1101. 1102. 1103. 1104. 1105. 1106. 1107. 1108. 1109. 1110. 1111. 1112. 1113. 1114. 1115. 1116. 1117. 1118. 1119. 1120. 1121. 1122. 1123. 1124. 1125. 1126. 1127. 1128. 1129. 1130. 1131. 1132. 1133. 1134. 1135. 1136. 1137. 1138. 1139. 1140. 1141. 1142. 1143. 1144. 1145. 1146. 1147. 1148. 1149. 1150. 1151. 1152. 1153. 1154. 1155. 1156. 1157. 1158. 1159. 1160. 1161. 1162. 1163. 1164. 1165. 1166. 1167. 1168. 1169. 1170. 1171. 1172. 1173. 1174. 1175. 1176. 1177. 1178. 1179. 1180. 1181. 1182. 1183. 1184. 1185. 1186. 1187. 1188. 1189. 1190. 1191. 1192. 1193. 1194. 1195. 1196. 1197. 1198. 1199. 1200. 1201. 1202. 1203. 1204. 1205. 1206. 1207. 1208. 1209. 1210. 1211. 1212. 1213. 1214. 1215. 1216. 1217. 1218. 1219. 1220. 1221. 1222. 1223. 1224. 1225. 1226. 1227. 1228. 1229. 1230. 1231. 1232. 1233. 1234. 1235. 1236. 1237. 1238. 1239. 1240. 1241. 1242. 1243. 1244. 1245. 1246. 1247. 1248. 1249. 1250. 1251. 1252. 1253. 1254. 1255. 1256. 1257. 1258. 1259. 1260. 1261. 1262. 1263. 1264. 1265. 1266. 1267. 1268. 1269. 1270. 1271. 1272. 1273. 1274. 1275. 1276. 1277. 1278. 1279. 1280. 1281. 1282. 1283. 1284. 1285. 1286. 1287. 1288. 1289. 1290. 1291. 1292. 1293. 1294. 1295. 1296. 1297. 1298. 1299. 1300. 1301. 1302. 1303. 1304. 1305. 1306. 1307. 1308. 1309. 1310. 1311. 1312. 1313. 1314. 1315. 1316. 1317. 1318. 1319. 1320. 1321. 1322. 1323. 1324. 1325. 1326. 1327. 1328. 1329. 1330. 1331. 1332. 1333. 1334. 1335. 1336. 1337. 1338. 1339. 1340. 1341. 1342. 1343. 1344. 1345. 1346. 1347. 1348. 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2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 22

11083

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

47

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balt</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 97 Poplar Rd Cedar Beach</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Milton M Knapp</u>				4. DATE OF DEATH Month <u>11</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/19/1896</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DAITO. CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>MORITZ KNAPP</u>				14. MOTHER'S MAIDEN NAME <u>CHRISTINA ZORN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W. I</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>ETTA M KNAPP</u>				Address <u>SAME AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>HYPERTENSION</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J Connelly</u>				ADDRESS <u>418 Eastern Ave.</u>		24a. REC'D BY REGISTRAR <u>John J Connelly</u>	
				DATE <u>11-12-56</u>			

MEDICAL CERTIFICATION

Case 21-mb.

1940

NO

1940

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11065

11084

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>66 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>6911 Railway Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>KONDRAT</u> Middle <u>(Also: KOMISAR) (NMI)</u> Last <u>KOMIZAR</u>				4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/95</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicholi Komizar</u>				14. MOTHER'S MAIDEN NAME <u>Taklia MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (If yes, give war or dates of service) <u>WW-I</u>		16. SOCIAL SECURITY NO <u>213 09 3164</u>		17. INFORMANT <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF ESOPHAGUS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 24, 1956</u> , to <u>November 29, 1956</u> , that I last saw the deceased alive on <u>November 29, 1956</u> and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Francis G. Dickey</u> M.D. <u>VAH, Fort Howard, Maryland</u> <u>11/30/56</u> PHYSICIAN'S NAME (Type) <u>FRANCIS G. DICKEY, M.D., Chief, Medical Service</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>DEC 3 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY TRINITY CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dippel Brothers, Inc. 1800 E. Lombard, Balto., Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 3 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Furler</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11085

## CERTIFICATE OF DEATH

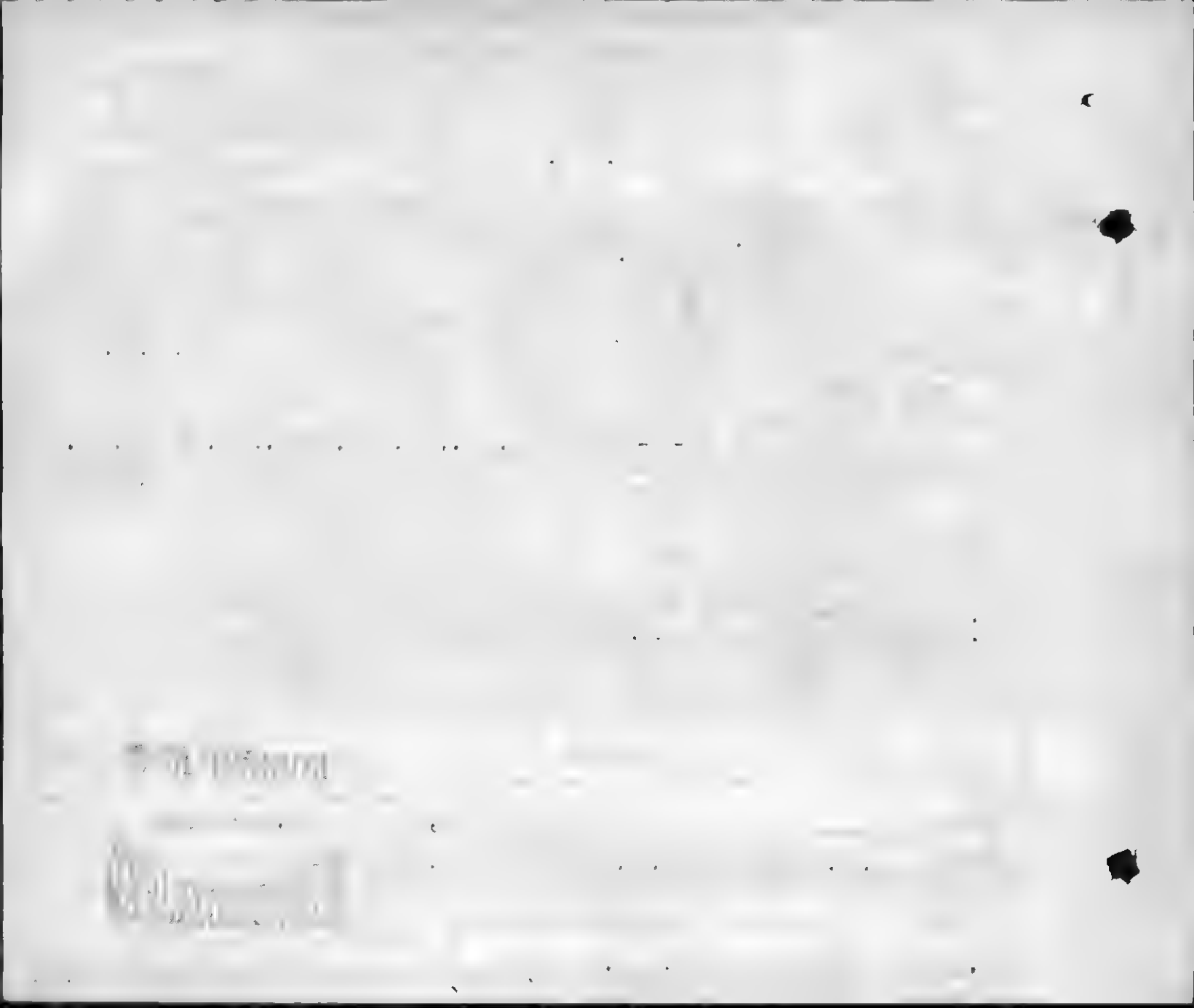
Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN 1b <b>11 Hrs. 40 M.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1828 Alice Anne Street</b> e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>(Also: WIKTON S. &amp; VIKTON S. VIKTOR S. KULIKOSKI)</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/8/94</b>
9. AGE (In years last birthday) <b>62</b> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Repair</b>	
11. BIRTHPLACE (State or foreign country) <b>Lubin, Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Leo Kulikoski</b>		14. MOTHER'S MAIDEN NAME <b>Stella</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO <b>217-01-9182</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Biliary cirrhosis</b> <b>2. Stone in common bile duct.</b> <b>3. Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. _____ 19 <b>56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>November 11, 1956</b> to <b>November 11, 1956</b> and that death occurred at <b>11:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. J. Papastradt M.D.</b>		ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b>	
DATE SIGNED <b>11/13/56</b>			
PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRADT, M. D.</b>		<b>VAH, Fort Howard, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-16-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight Funeral Home, Inc.</b>		24a. REC'D BY REGISTRAR <b>DATE 11-28-56</b>	
ADDRESS <b>Wm. Cook-Blight Funeral Home, Inc.</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. Dawson S. Parker</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## 11086 CERTIFICATE OF DEATH

11067

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u> LENGTH OF STAY (in this place) <u>6 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE Co.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2111 VALETHORN ROAD</u>		STREET ADDRESS (If rural give location) <u>2111 VALETHORN Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Arthur</u>	(First) <u>Arthur</u>	(Middle) <u>Landon</u>	(Last)
4. DATE OF DEATH <u>Nov 18</u>	(Month)	(Day)	(Year) <u>1956</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-7-1882</u>
9. AGE last birthday <u>74</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>CRISFIELD - MD</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN LANDON</u>		14. MOTHER'S MAIDEN NAME <u>THOMPAS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>218-01-2384</u>	
(If yes, give war or dates of service)		17. INFORMANT <u>MRS. CARRIE LANDON 2111 VALETHORN Rd</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a).....

Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b).....

Coronary Arteriosclerosis

10 yrs.

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY

INJURY OCCURRED  
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased (from....., 19....., to....., 19.....) that I last saw the deceased

alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

#### 23. BURIAL, CREMATION REMOVAL (Specify)

#### DATE THEREOF

#### NAME OF CEMETERY OR CREMATORY

#### LOCATION (City, town, or county)

#### (State)

DATE REG'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

11/20/56

W. W. Neff

Thomas J. Kenny Inc 1606 Hillis St

BALTO - MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



## 10973 CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>711 Aldworth Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alfred J Lentz</b>		4. DATE OF DEATH Month Day Year <b>Nov 1 1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 18 1908</b>
9. AGE (In years last birthday) <b>48</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shell Trucking Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Louis J Lentz</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Kowling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>7-772</b>	
17. INFORMANT <b>Charles V Lentz</b>		Address <b>711 Aldworth Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4:00.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <b>Coronary thrombosis</b> <b>Coronary vessels sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>approx 20 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/2/36</b> 19, to <b>11/2/56</b> , 19, that I last saw the deceased alive on <b>11/2/56</b> , 19, and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Osvaldo Berris</b> M.D.		10/3/56	
PHYSICIAN'S NAME (Type) <b>OSVALDO BERRIS MD</b>		<b>Balto. Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Nov 5/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home</b>		ADDRESS <b>2112 Dundalk Ave</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 8 1956</b>		24b. REGISTRAR'S SIGNATURE <b>John M. Kelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JAN 1 1901  
U. S. ARMY

11087

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>		c. LENGTH OF STAY IN 1b <u>34 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1017 RoseDAle Ave.</u>		d. STREET ADDRESS <u>1017 RoseDAle Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>Jacob</u> Middle <u>LEVY</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>6</u> Day <u>1956</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Distillery man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Distillery Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Yaclov Levy</u>		14. MOTHER'S MAIDEN NAME <u>Antoine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-666</u>	
17. INFORMANT <u>Josephine Levy</u>		Address <u>1017 RoseDAle Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>	20d. INJURY OCCURRED, While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>June</u> 19 <u>54</u> , to <u>Nov. 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 6</u> , 19 <u>56</u> , and that death occurred at <u>8:25</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R. Mason, M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>8019 Philadelphia Rd.</u> DATE SIGNED <u>Nov. 7, 1956</u>	
PHYSICIAN'S NAME (Type) <u>James R. Mason, M. D.</u>		<u>Baltimore 6, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 19, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	22d. LOCATION (City, town, or county) <u>Balto. Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip F. Couch</u> ADDRESS <u>2716 E. Monument St.</u>		24a. REC'D BY REGISTRAR <u>Nov. 8, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Edith Harley</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. S.

NOV.

1914

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1107038

11088

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1005 Malvern Ave</u>				d. STREET ADDRESS <u>1005 Malvern Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Janet Gordon Lewin</u>				4. DATE OF DEATH Month Day Year <u>11 9 1956</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 11 1910</u>	
9. AGE (In years last birthday) <u>46</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Baeto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr Albert Keidel</u>				14. MOTHER'S MAIDEN NAME <u>Janett Gordon Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John Henry Lewin</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153x</u> DUE TO <u>Carcinoma of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>153x</u> DUE TO <u>153x</u> (c) <u>153x</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 7th 1956</u> to <u>Nov 10</u> , 1956 that I last saw the deceased alive on <u>Nov. 7th 1956</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A Murray Fisher</u> M.D.		ADDRESS (Street, city or town, state) <u>18 E. Eager St. Baltimore - 2. Md.</u>		DATE SIGNED <u>11/9/56</u>			
PHYSICIAN'S NAME (Type) <u>A Murray Fisher</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 12 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Baeto, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. W. Smith</u>		ADDRESS <u>4905 York Rd</u>		24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10974 CERTIFICATE OF DEATH

1107141

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>3426 LOUTH RD.</u>	
3. NAME OF DECEASED (Type or print) <u>LEWIS</u> <u>FIRST</u> <u>MIDDLE</u> <u>MITTYE JENKINS</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MATE JENKINS</u>		14. MOTHER'S MAIDEN NAME <u>MARY CRAWFORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>MRS. FLOSSY BROOKS (DAUGHTER)</u>		Address <u>3426 LOUTH RD. DUNDALK, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u> <u>7 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>22-NOV</u> , 19 <u>56</u> , to <u>23 NOV</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>22 NOV</u> , 19 <u>56</u> , and that death occurred at <u>3:00 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. Baermann</u> M.D.		ADDRESS (Street, city or town, state) <u>DR. W. E. BAERMANN</u> <u>33 DUNDALK AVENUE</u> <u>DUNDALK 22, MARYLAND</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-26-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. CO, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Bradley, Dundalk, MD</u>		24a. REC'D. BY REGISTRAR DATE <u>V 28 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Mr. Kelly</u>

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BUREAU A. S.

## 11089 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>18</b> <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>22 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>C.</b> Last <b>LINTHICUM</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/19/99</b>	9. AGE (In years last birthday) <b>57 yrs</b>	IF UNDER 1 YEAR Months <b>57</b> Days <b>19</b> Hours <b>56</b> Min <b>56</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>New York, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John C. Linthicum</b>				14. MOTHER'S MAIDEN NAME <b>Helen Perry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WW-I</b>				16. SOCIAL SECURITY NO <b>549 18 6624</b>			
17. INFORMANT <b>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LARYNX WITH METASTASIS</b> DUE TO (b) <b>TO LUNGS AND NECK</b> DUE TO (c) <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>November 24, 19 56</b> , to <b>November 24, 19 56</b> , and that death occurred at <b>3:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Md.</b> DATE SIGNED <b>11/24/56</b>							
ACTUAL SIGNATURE <b>James Nolan</b>				PHYSICIAN'S NAME (Type) <b>JAMES X. NOLAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/27/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Ritchie Highway Baltimore, Md.</b>				22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>128 E. Fort Ave. Baltimore, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 11/27/56</b>			
24b. REGISTRAR'S SIGNATURE <b>Ransom L. Halsey</b>				24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG207 11-20-56 et

## CERTIFICATE OF DEATH

11073

Reg. Dist. No.

11090

1. PLACE OF DEATH a. COUNTY <b>Baltimore Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
b. <b>Life</b>		c. <b>Middle River Baltimore 6</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ivy Hall Nursing Home</b>		d. STREET ADDRESS <b>1126 Grape Hill Ave. AD Harrison Ave Middle River, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roy Percival</b> Middle <b>Long</b> Last <b>Long</b>		4. DATE OF DEATH Month <b>11/9/56</b> Day <b>1956</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1886</b>
9. AGE (In years last birthday) yrs. <b>70</b>		IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penn.</b>	
11. BIRTHPLACE (State or foreign country) <b>Alburton, Howard Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Daniel Long</b>		14. MOTHER'S MAIDEN NAME <b>Hettie W. Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>717-07-7026</b>	
17. INFORMANT <b>Chester Schaffer</b>		Address <b>4126 Grape Hill Rd. 6</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Lung</b> <b>163X</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Squamous Cell Carcinoma of Larynx</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1953</b> , to <b>1956</b> , that I last saw the deceased alive on <b>NOVEMBER 8, 1956</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harvey L. Fuller</b> M.D.		ADDRESS (Street, city or town, state) <b>RIDGE RD. BALTIMORE 6, MD</b> DATE SIGNED <b>11/14/56</b>	
PHYSICIAN'S NAME (Type) <b>HARVEY L. FULLER, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/12/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	22d. LOCATION (City, town, or county) (State) <b>Pikerville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sassa Funeral Home</b>		ADDRESS <b>7401 Belair rd. 6</b>	
24a. REC'D BY REGISTRAR <b>NOV 13 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurler</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, burn, or destroy papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11091 CERTIFICATE OF DEATH

11074

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>19 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1422 N. Gay Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>L.</b> Last <b>LUCAS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/10/13</b>	
9. AGE (In years last birthday) <b>43</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Spring Hope, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Spring Hope, N. Carolina</b>	
13. FATHER'S NAME <b>Grover Lucas</b>				14. MOTHER'S MAIDEN NAME <b>Joney May Langley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>				16. SOCIAL SECURITY NO. <b>237-10-8964</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO <b>CHRONIC GLOMERULONEPHRITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension due to chronic glomerulonephritis. 2. Cardiac enlargement</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b> <b>10 YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 29, 1956</b> , to <b>November 17, 1956</b> , and that death occurred at <b>2:55 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. J. Papastrat M.D.</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>11/19/56</b>			
PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>				24b. REGISTRAR'S SIGNATURE <b>Dawson L. Torrey</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11/21/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Keysville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, North Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law Mortuary, 802-04 Madison Ave.</b>				24a. REC'D BY REGISTRAR <b>DATE 11/21/56</b>		24b. REGISTRAR'S SIGNATURE	

Shipped To: Leon Randolph, Jr., Washington, N. Carolina

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11092 CERTIFICATE OF DEATH

11975

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Georgetown</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Augustsburg Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Ann Lutz</u>		4. DATE OF DEATH <u>Nov 13 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 24 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>York Pa</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm R Lutz</u>		14. MOTHER'S MAIDEN NAME <u>Christiana Wilkerson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>8-1-1</u>	
17. INFORMANT <u>Records</u>		Address <u>6711 Campfield Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardio</u> DUE TO <u>Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile Dementia</u> (c) <u>Senile Dementia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio-sclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 2</u> , 19 <u>54</u> , to <u>11/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/8</u> , 19 <u>56</u> , and that death occurred at <u>11:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u>		ADDRESS (Street, city or town, state) <u>4108 Liberty Hts Balto Md</u> DATE SIGNED <u>11-14-56</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers M. D. 4108 Liberty Heights Avenue Baltimore 7, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/17/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cem</u>	22d. LOCATION (City, town, or county) (State) <u>York Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Deane</u>		ADDRESS <u>Harford Rd</u>	
24a. REC'D BY REGISTRAR <u>NOV 13 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm E. Martin</u>	

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## 11093 CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence May MacCubbin</u>		4. DATE OF DEATH Month Day Year <u>Nov 7 1956 19</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5th 1910</u> 9. AGE (In years last birthday) <u>46</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Baldwin Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. T. McCubbin</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Watkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John MacCubbin Baldwin Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Duodenal scarring</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 13, 1956</u> , to <u>Nov. 7, 1956</u> , that I last saw the deceased alive on <u>Oct. 13, 1956</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>11-8-56</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-10-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Sweet Air Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Morton E. Knitz</u> ADDRESS <u>Greenleaf</u>		24a. REC'D BY REGISTRAR <u>W. M. Hammett</u> DATE <u>11-9-56</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11094

CERTIFICATE OF DEATH

11076

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN b <b>175 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1810 California Street, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DONALD</b> Middle <b>(NMI)</b> Last <b>MACK</b>		4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 14, 1910</b>
9. AGE (In years last birthday) <b>46</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	11. BIRTHPLACE (State or foreign country) <b>Charles County, Maryland</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Boiler- Steel Co.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Robert Mack</b>		14. MOTHER'S MAIDEN NAME <b>Hettie MN: Miles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>578-09-5599</b>	
17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>163x CARCINOMA OF LEFT UPPER LOBE OF LUNG WITH METASTASES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 28, 1956</b> , to <b>November 19, 1956</b> , and that death occurred at <b>9:15 A.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>C. J. Papastrat M.D.</b>		DATE SIGNED <b>11/20/56</b>	
PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>		ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11-26-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest Lewis</b>		24a. REC'D BY REGISTRAR <b>DEC 3 1956</b>	
ADDRESS <b>Ernest Lewis Funeral Home, Washington, D. C.</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Carleton</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

11095										MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12186																			
										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.																			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>																													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>										c. LENGTH OF STAY IN 1b										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)										d. STREET ADDRESS <u>8000 Eastern Ave.</u>										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Allen Madison</u>										4. DATE OF DEATH Month Day Year <u>11 17 19 56</u>																													
5. SEX <u>M</u>										6. COLOR OR RACE <u>W</u>										7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH									
9. AGE (In years last birthday) <u>42</u> yrs										IF UNDER 1 YEAR Months Days										IF UNDER 24 HRS. Hours Min.																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10b. KIND OF BUSINESS OR INDUSTRY										11. BIRTHPLACE (State or foreign country)										12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)										16. SOCIAL SECURITY NO. (If yes, give war or dates of service)										17. INFORMANT Address																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive CARDIOVASCULAR Disease</u> <u>4-2-2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																													
20c. TIME OF INJURY Month, Day, Year Hour a. m p. m <u>19</u>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																																							
ACTUAL SIGNATURE <u>Jack C. Collins</u>										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED																			
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
22a. BURIAL, CREMATION, REINTERMENT (Specify)										22b. DATE THEREOF <u>12-11-56</u>										22c. NAME OF CEMETERY OR CREMATORY <u>Univ. of Md. Med. School</u>										22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE										ADDRESS										24a. REC'D BY REGISTRAR DATE <u>DEC 18 56</u>										24b. REGISTRAR'S SIGNATURE <u>Outreach</u>									

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11095

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH o COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Loch Raven Village</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Loch Raven Village</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8352 Loch Raven Blvd.</b>		d. STREET ADDRESS <b>8352 Loch Raven Blvd.</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>J.</b> Last <b>MALCHODI</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>13</b> Year <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 27, 1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cement Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cement</b>	9. AGE (In years last birthday) <b>64</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>N. Y.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Adolph Malchodi</b>		14. MOTHER'S MAIDEN NAME <b>Virginia (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Ernest Malchodi - 1622 Hardwick Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b> <b>4 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 13, 1956</b> , to <b>Nov. 13, 1956</b> , that I last saw the deceased alive on <b>Nov. 12, 1956</b> , and that death occurred at <b>3 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph F. Li Pira</b>		ADDRESS (Street, city or town, state) <b>8400 Loch Raven Blvd, BALTO, Md.</b>	
PRINTED NAME (Type) <b>JOSEPH F Li Pira</b>		DATE SIGNED <b>4, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/15/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thm. J. Lickner &amp; Sons - Balto 17, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov. 14, 1956</b>	
		24b. REGISTRAR'S SIGNATURE <b>Dr. H. M. Bacon</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. (Page 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2.

NOV 3 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

30-

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryl.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>22 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Regimental General Wade Hosp.</u>				d. STREET ADDRESS <u>324 S. Airport Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine T. Malone</u> First Middle Last				4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14, 1869</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Malone</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Fitzpatrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Regimental General Wade Hosp.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>unknown</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 22, 1934</u> to <u>Nov. 18, 1956</u> that I last saw the deceased alive on <u>Nov. 18, 1956</u> and that death occurred at <u>5:04 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles Ward</u> M.D. <u>Spring Grove Hosp.</u>				DATE SIGNED <u>11/18/56</u>			
PHYSICIAN'S NAME (Type) <u>DR. CHARLES WARD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov. 19, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. M. Walters</u> ADDRESS <u>1414 N. E. St.</u>				24a. REC'D BY REGISTRAR <u>F. E. Harris</u> DATE		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM V. S.

100

100

11098 CERTIFICATE OF DEATH

11079  
Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>		c. LENGTH OF STAY IN 1b <b>Rosedale</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1318 Pine Grove Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1956</b>		5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 24, 1906</b>		9. AGE (In years last birthday) <b>49 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operating Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Walsh Constr. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Chestertown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Josiah A. Massey</b>		14. MOTHER'S MAIDEN NAME <b>Helen Gooding</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-09-0374</b>		17. INFORMANT <b>Clara Debelius Massey, wife, above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-Vascular disease</b> DUE TO (c) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>2 yrs</b> <b>6 yrs</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>a. p.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from <b>Nov 20, 1956</b> to <b>Nov 20, 1956</b> that I last saw the deceased alive on <b>Nov 20, 1956</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. M. Baumgardner</b>		M.D. <b>Baltimore Md</b>		DATE SIGNED <b>11/20/56</b>		PHYSICIAN'S NAME (Type) <b>G. M. Baumgardner, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 23, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimmek Funeral Home, Inc.</b>		ADDRESS <b>2601 E. Madison St.</b>		24a. REC'D BY REGISTRAR DATE <b>11-21-56</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11099 CERTIFICATE OF DEATH

Reg. Dist. No. **11080** 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>144 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>7 East Centre Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>M.</b> Last <b>MC LIN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 27, 1889</b>	
				9. AGE (In years last birthday) yrs. <b>67</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>Logan, Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Andrew McLin</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Knott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>217-18-5159</b>		17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE ESOPHAGUS WITH METASTASES</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <b>7 MONTHS</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 3, 19 56</b> to <b>November 26, 19 56</b> and that death occurred at <b>1:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>C. J. Papastrat</b> M.D.				Veterans Administration Hospital <b>11/27/56</b>			
PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>				Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-29-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>				ADDRESS <b>6009 Harford Rd., Balto. 14, Md.</b>		24a. REC'D BY REGISTRAR <b>C 3 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>James L. Farber</b>			

S. A. R.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11100 CERTIFICATE OF DEATH

110830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>938 S. Clinton Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>V.</u> Last <u>Meehan</u>		4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>19 56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1883</u>
9. AGE (In years last birthday) yrs. <u>73</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Emma Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the rectum - colostomy</u>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 19, 1953</u> to <u>Nov. 12, 1956</u> that I last saw the deceased alive on <u>November 12, 1956</u> , and that death occurred at <u>6:30 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 11-13-56</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/16/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	22d. LOCATION (City, town, or county) (State) <u>BAKTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		24a. REC'D BY REGISTRAR <u>Balt. 21-2nd Nov 16 1956</u>	
ADDRESS <u>Balt. 21-2nd Nov 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>V. C. Dary</u>	

BUREAU A. M.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11101 CERTIFICATE OF DEATH

11082 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>29 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>1004 W. 40th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>A</u> Last <u>MEYER</u>		4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/91</u>
9. AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sexton Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cincinnati, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Meyer</u>		14. MOTHER'S MAIDEN NAME <u>Emma Keller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-I</u>		16. SOCIAL SECURITY NO. <u>138 03 2628</u>	
17. INFORMANT <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYDRONEPHROSIS</u>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 4, 19 56</u> , to <u>November 2, 19 56</u> , and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. J. Papastrat M.D.</u>		ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Md.</u> DATE SIGNED <u>11-3-56</u>	
PHYSICIAN'S NAME (Type) <u>C. J. PAPASTRAT</u>		M.D. <u>VAH, Fort Howard, Md.</u> <u>11-3-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Nov 7, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>	
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>Donovan Funeral Home, 3818 Roland Ave</u>	
24a. REC'D BY REGISTRAR <u>DATE 15 11</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Garber</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. P.

1966

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11102

## CERTIFICATE OF DEATH

11082

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>			
c. LENGTH OF STAY IN 1b <u>1 yr, 27 d</u>				d STREET ADDRESS <u>3931 Clark Lane</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) <u>Spring Grove State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Leonard</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>November</u> Day <u>4</u> Year <u>19 56</u>			
5 SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-4-1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Hyman Miller</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		(If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: Spring Grove State Hosp. -</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Oct. 12</u> , 19 <u>55</u> , to <u>Nov. 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 4</u> , 19 <u>56</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp.</u>			
DATE SIGNED <u>11-4-1956</u>							
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u> <u>Catonville 28, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-5-56</u>		<u>Arlington</u>		<u>Balto, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u>				ADDRESS <u>2100 Brittan Pl</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. B. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4)  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUL 2 1956  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11084

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER MD</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7-FERN PLACE</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 20</u> d. STREET ADDRESS <u>7 FERN PLACE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARIA</u> First <u>GRACE</u> Middle <u>MORGAN</u> Last <b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>11</u> Year <u>1956</u>		<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Aug 4 - 1906</u> <b>9. AGE</b> (In years last birthday) <u>50</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>TEL OPERATOR</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S.F. &amp; G. Co</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>BALTIMORE MD</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>RICHARD HUGHES</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>NOT KNOWN</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u>21501-7312</u> <b>16. SOCIAL SECURITY NO.</b> <u>21501-7312</u> <b>17. INFORMANT</b> <u>RAYMOND MORGAN 7-FERN PLACE</u> Address		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>400.1</u> DUE TO (c)	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> o. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>Jack C Collins</u> <b>EXAMINER'S NAME (Type)</b> <u>JACK C COLLINS</u>		<b>CHIEF MEDICAL EXAMINER <input type="checkbox"/></b> <b>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></b> <b>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>22b. DATE THEREOF</b> <u>11/15/56</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>RAK LA WIV</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>BALTIMORE MD</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Edith Bailey</u> <b>24b. REGISTRAR'S SIGNATURE</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Blair H. Hoffmann</u> <b>ADDRESS</b> <u>3218 Hudson St</u>		<b>DATE</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the registration number prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11104 CERTIFICATE OF DEATH

110858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2625 Wendover Road</u>		d. STREET ADDRESS <u>2625 Wendover Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. George L. (Pete) Moss</u>		4. DATE OF DEATH Month Day Year <u>November 20st 19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 20, 1903</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer Waverly Press</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Moss</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Schleiger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>216-07-0074</u>	
17. INFORMANT <u>Mrs. Dorothy M. Moss, 2625 Wendover Rd</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>100X Metastatic Carcinoma of Lungs</u> DUE TO (b) <u>Primary Carcinoma of Esophagus</u> DUE TO (c) <u>1 1/2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Month</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 1948</u> to <u>November 1956</u> that I last saw the deceased alive on <u>November 18, 1956</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>7501 York Rd</u> DATE SIGNED <u>11/23/56</u>	
PHYSICIAN'S NAME (Type) <u>T. W. S. #4 M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/24/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Hargord Road #14</u>	
24a. REC'D BY REGISTRAR <u>NOV 23 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar's office within 72 hours after death.

BUREAU V. E.

NOV 3 1956

RECEIVED

## 11105 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2115 Gwynn Oak Avenue</b>		d. STREET ADDRESS <b>2115 Gwynn Oak Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>First LOUISA Middle C. MULLINEAUX Last</b>		4. DATE OF DEATH <b>November, 28th 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June, 25th 1857</b>
9. AGE (In years last birthday) <b>99</b> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Loos</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Steckell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, how long; if yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Ruth Mullineaux</b>		Address <b>2115 Gwynn Oak Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary artery disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs.</b>
20a. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> 19 <b>56</b> p. m. <b>None</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>
20f. (City or town) <b>None</b> (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>April 1948</b> to <b>Nov. 28 1956</b> , that I last saw the deceased alive on <b>Nov. 27 1956</b> , and that death occurred at <b>10:45 M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Carl Myers</b>		ADDRESS (Street, city or town, state) <b>1401 East Cold Spring Lane</b>	
PHYSICIAN'S NAME (Type) <b>J.C. Myers</b>		DATE SIGNED <b>M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 1st 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Myers, Annapolis</b>		24a. REG'D BY REGISTRAR <b>DEC 3 1956</b>	
ADDRESS <b>4510 Liberty Heights Avenue</b>		24b. REGISTRAR'S SIGNATURE <b>Mr. Wm. E. Marling</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director, and in any event within 72 hours after death.

RECEIVED

1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the file of the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

11106 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11087  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balt</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt. 19</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 16</u>	
3. NAME OF DECEASED (Type or print) <u>ERNEST E. MURPHY</u>		d. STREET ADDRESS <u>3029 Gwynns Falls Pkwy</u>	
4. DATE OF DEATH Month <u>11</u> Day <u>22</u> Year <u>1956</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-27-11</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Booby Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WALTER MURPHY</u>		14. MOTHER'S MAIDEN NAME <u>BETTY TUCK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>111-26-156</u>	
17. <u>WIFE, SUSIE E. MURPHY</u>		18. <u>3029 Gwynns Falls Pkwy.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>11-22-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 26, '56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Cemo.</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>1651 Smith Hill</u>		24. REC'D BY REGISTRAR <u>11-26-1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Lander</u>	

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1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>2yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. STREET ADDRESS <b>459 Brunswick St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jennie A. Pfeiffer Murphy</b>				4. DATE OF DEATH Month Day Year <b>November 8, 19 56</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 30, 1879</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Edward Pfeiffer</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Kesting</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Diabetes mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 26, 1956</b> , to <b>Nov. 8, 1956</b> , that I last saw the deceased alive on <b>Nov. 8, 1956</b> , and that death occurred at <b>6:30a M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>			
DATE SIGNED <b>11-8-56</b>							
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				Catonsville 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>11-12-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>London Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
20. FUNERAL DIRECTOR'S SIGNATURE <b>Ed. J. Wilson</b>				ADDRESS <b>4107 Wilson Ave.</b>			
24a. REC'D BY REGISTRAR DATE <b>9 1956</b>				24b. REGISTRAR'S SIGNATURE <b>J. E. Barry</b>			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5 111-0207 11-19-56

11089

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armcoast Nursing Home-812 Register Ave</b>				d. STREET ADDRESS <b>7106 Bristol Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First <b>MARY</b> Middle <b>L.</b> Last <b>MURRELL</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>16,</b> Year <b>56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 24, 1867</b>		9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>N. C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Hillen Harrell</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Draper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mr. Harry B. Lentz-7106 Bristol Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Sclerosis</b> DUE TO <b>Arterio Sclerotic Cardiac Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Semility</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1956</b> , 19____, to <b>Nov 16</b> , 19____, that I last saw the deceased alive on <b>Nov 16</b> , 19____, and that death occurred at <b>4:30</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3033 W North St</b> DATE SIGNED ACTUAL SIGNATURE <b>M Paul Byerly</b> M.D. PHYSICIAN'S NAME (Type) <b>M Paul Byerly</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/19/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Dickner &amp; Sons - Balto. 17th</b>				24a. REC'D BY REGISTRAR DATE <b>11-19-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) b. STATE <b>Pennsylvania</b> b. COUNTY <b>York</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>York</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>654 York Street</b>	
3. NAME OF DECEASED (Type or print) First <b>RAY</b> Middle <b>B.</b> Last <b>MUSSER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1914</b>
9. AGE (In years last birthday) yrs. <b>42</b>		IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min <b></b> IF UNDER 24 HRS. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Test Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Refrigeration</b>	
11. BIRTHPLACE (State or foreign country) <b>York, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lloyd Musser</b>		14. MOTHER'S MAIDEN NAME <b>Marie McKinney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WW II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERINEPHRIC ABSCESS, RIGHT</b> <b>600.1</b> DUE TO (b) <b>UNKNOWN</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Other cond. cont. 1. Bronchopneumonia, right lung.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Aneurysm of the middle cerebral artery. 2. Decubitus ulcers of the right and left hip and the sacral area. 3. Thrombosis of the rt. common iliac artery</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>iliac artery</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>VA</b> 19 p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 20, 1956</b> to <b>November 27, 1956</b> and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>C. J. Papa M.D.</b>		M.D. <b>VA HOSPITAL, FORT HOWARD, MARYLAND 11/28/56</b>	
PHYSICIAN'S NAME (Type) <b>C. J. PAPA STRAT, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11-29-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>York, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b>		24a. REC'D BY REGISTRAR <b>DATE 12-2-56</b>	
ADDRESS <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 11, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Parker</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. 071610

PLATE 35

11110

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>14 E. CHESAPEAKE AVE.</b>				d. STREET ADDRESS <b>14 E. CHESAPEAKE AVE.</b>			
3. NAME OF DECEASED (Type or print) <b>AUGUSTUS REED Naylor, Jr.</b>				4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1956</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 23, 1911</b>	
9. AGE (in years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AUTO MECHANIC</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FORD AGENCY REP.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>AUGUSTUS REED NAYLOR</b>				14. MOTHER'S MAIDEN NAME <b>KATIE JEANETTE SUTTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW II</b>				16. SOCIAL SECURITY NO. <b>216-03-8246</b>		17. INFORMANT <b>FAMILY RECORDS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Acute to Chronic Alcoholism</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>7 Days</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Charles F O'Donnell</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles F O'Donnell MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/6/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. ZION CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>HAMPSTEAD, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Brown</b>				ADDRESS <b>TOWSON, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE 11/6/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

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CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lawrence Nursing Home</u>		d. STREET ADDRESS <u>201 Tuscan Road</u>	
3. NAME OF DECEASED (Type or print) <u>AMY PARKER NEILSON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4. DATE OF DEATH <u>Nov 30 1956</u>
8. DATE OF BIRTH <u>Aug 4 1942</u>	9. AGE (In years last birthday) <u>14</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Balto, Md</u>	11. BIRTHPLACE (State or foreign country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Parker Neilson Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Laura Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Charles W Frost</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN tumor (Ependymoma)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1953</u> to <u>Nov 30 1956</u> , that I last saw the deceased alive on <u>October 25 1956</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. G. Speed</u>		ADDRESS (Street, city or town, state) <u>11 E. Chan St.</u>	
DATE SIGNED <u>11/30/56</u>			
PHYSICIAN'S NAME (Type) <u>William G. Speed, 3rd, M.D. Baltimore 2, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 1 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold H. McKinnon</u>		ADDRESS <u>4915 York Road</u>	
24a. REC'D BY REGISTRAR <u>DEC 4 1956</u>		24b. REGISTRAR'S SIGNATURE <u>T. C. Barry</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 4 1950

150



11112

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2mths5dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Lee</b> Last <b>Nelson</b>		4. DATE OF DEATH Month <b>November</b> Day <b>19</b> , Year <b>19 56</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 28, 1886</b>
9. AGE (In years last birthday) <b>70 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>220-22-7631</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 15, 19 56</b> to <b>Nov. 19, 19 56</b> , that I last saw the deceased alive on <b>Nov. 19, 19 56</b> , and that death occurred at <b>2:45a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 11-19-56</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 21, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Paran Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Randallstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>		ADDRESS <b>4600 Liberty Heights</b>	
24a. REC'D BY REGISTRAR <b>W. E. Harvey</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Harvey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4a may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



U. A. (173)

12



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10975 CERTIFICATE OF DEATH

11094

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND.</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1742 BROOKSVIEW ROAD</b>		d. STREET ADDRESS <b>1742 BROOKSVIEW ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LILLIAN L. NODOLNEY</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>17</b> Year <b>1956</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 18, 1893</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>VERNON McCLURE</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE STREBECK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>MR. JOSEPH A. NODOLNEY</b>		Address <b>SAME.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>HYPERTENSIVE C-V DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **Feb.**, 19**50**, to **11-17**, 19**56**, that I last saw the deceased alive on **11-16**, 19**56**, and that death occurred at **7 A.M.** from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **1943 CEDAR LANE BALTO. MD. 11/7/56** DATE SIGNED

ACTUAL SIGNATURE **Daniel L. Zalis** M.D. **1943 CEDAR LANE BALTO. MD. 11/7/56**

PHYSICIAN'S NAME (Type) **DANIEL L. ZALIS**

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/20/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>ELKRIDGE MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC.</b>		24a. REC'D BY REGISTRAR <b>Wm. M. Kelly, Jr.</b>	
BALTIMORE 13, MARYLAND.		DATE <b>11-21-56</b>	

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician. TO BE FILLED BY FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5. 11. 1956

1956

1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11095

Reg. Dist. No.

10976

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTHBROOK</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7833 EASTDALE RD.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO, 24, NORTHBROOK</u>	
		d. STREET ADDRESS <u>7833 Eastdale Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Hugh</u> Middle <u>Thomas</u> Last <u>O'Connor</u>		4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 19, 1914</u>
9. AGE (in years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAT. DET. AGENCY</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS F. O'CONNOR</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET E. SCHMEISER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>213-074654</u>	
17. INFORMANT <u>PEARL O'CONNOR</u>		Address <u>SAME.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia - Left</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>12 hrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack E. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack E. Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-27-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>7801 GERMAN HILL RD., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Gailer</u>		24a. REC'D BY REGISTRAR <u>Nov. 27, 1956</u>	
ADDRESS <u>BALTO, 24, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Tom Kelly</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

NOV 2 1956

RECEIVED

11113 CERTIFICATE OF DEATH

11096

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>14yrs6mth24dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>2311 W. North Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>Osin</b> Last <b>Osin</b>		4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>unknown</b>
9. AGE (In years last birthday) yrs <b>78?</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clothing worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>clothing</b>	
11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Abraham Osin</b>		14. MOTHER'S MAIDEN NAME <b>Fiega Kaplin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Upper respiratory infection</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1953</b> to <b>Nov. 2, 1956</b> , that I last saw the deceased alive on <b>Nov. 2, 1956</b> , and that death occurred at <b>11:25 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 11-2-56</b>			
ACTUAL SIGNATURE <b>Rena Becker</b> M.D.		PHYSICIAN'S NAME (Type) <b>Rena Becker, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Burial</b>		<b>11-5-56</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Rosedale</b>		<b>Balto, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewin</b>		ADDRESS <b>3100 Eutan Pl</b>	
24a. REC'D BY REGISTRAR <b>NOV 7 1956</b>		24b. REGISTRAR'S SIGNATURE <b>V. E. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 1  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11098

11114

## CERTIFICATE OF DEATH

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore 15</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>2007 Ridgewood Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Maude</u> Last <u>Page</u>				4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1956</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 - 16 - 1877</u>		9. AGE (In years last birthday) <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard H. Ward</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. Fitchett</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Carroll C. Ward</u> Address <u>238 Patapsco Avenue Dundalk 22, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Pulmonary embolism</u> DUE TO <u>Thrombosis of Right inguinal veins</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic Carcinoma R. inguinal region</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Surgical removal of rectum for Carcinoma</u>								INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Ellis S. Margolin</u> M.D.				ADDRESS (Street, city or town, state) <u>Sykesville Maryland</u>				DATE SIGNED <u>11/10/56</u>	
NAME (Type) <u>ELLIS S. MARGOLIN, M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street, Balto.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>Nov. 14, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>T. E. Hargy</u>	

BUREAU V. S.

NOV 15 1956

RECEIVED

11115

## CERTIFICATE OF DEATH

11097

Reg. Dist. No. 45

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE COUNTY ESSEX</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>376 EVERGREEN LANE</b>				d. STREET ADDRESS <b>376 EVERGREEN LANE</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ADAM PAKASKI (PAKACKI)</b>				4. DATE OF DEATH Month Day Year <b>NOV. 4, 1956 19</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 20, 1894</b>		9. AGE (In years last birthday) <b>62</b>		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER OWN FARM</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>ADAM PAKASKI</b>			
14. MOTHER'S MAIDEN NAME <b>MARY MEKOLEN</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT Address <b>MRS CATHERINE PAKASKI SAME.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio Vascular renal</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct 15, 1956</b> to <b>Nov 4, 1956</b> , that I last saw the deceased alive on <b>Nov 4, 1956</b> , and that death occurred at <b>9 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b> M.D.				ADDRESS (Street, city or town, state) <b>Baltimore Md</b>			
PHYSICIAN'S NAME (Type) <b>[Signature]</b>				DATE SIGNED <b>11/5/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>NOV. 7, 1956</b>		<b>CHRIST CHURCH CEMETERY</b>		<b>BALTIMORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry Sander &amp; Sons Inc</b>				ADDRESS <b>Baltimore Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 7 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

U.S. DEPARTMENT OF AGRICULTURE

NOV 2 1956

W. A. HARRIS

10987 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Relay Hill</u>		LENGTH OF STAY (in this place) <u>5 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
TOWN <u>Relay Hill</u>				TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Relay Hill Hospital</u>				STREET ADDRESS (If rural give location) <u>3817 S. Hanover St.</u>			
3. NAME OF DECEASED: (First) <u>Mary</u> (Middle) <u>Elizabeth</u> (Last) <u>Peel</u>				4. DATE OF DEATH: (Month) <u>Nov.</u> (Day) <u>3</u> (Year) <u>1956</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Jan. 29, 1880</u>	
				9. AGE last birthday: <u>76</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>Frostburg Maryland</u>	
13. FATHER'S NAME: <u>Conrad Lepp</u>				14. MOTHER'S MAIDEN NAME: <u>Catherine Krapf</u>			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				17. INFORMANT & ADDRESS: <u>FAMILY 3817 S. HANOVER ST.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
(a) <u>Immediate cause</u> <u>Mediastinal Bleeding</u>		
(b) <u>Antecedent causes(s)</u> <u>Metastasis to Mediastinum</u>		
(c) <u>DUE TO</u> <u>Carcinoma of the Breast</u>		<u>1 hr</u> <u>?</u> <u>2 yrs</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>—</u>		19b. MAJOR FINDINGS OF OPERATION: <u>—</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct. 29, 1956, to Nov. 3, 1956, that I last saw the deceased alive on Nov. 3, 1956, and that death occurred at 10:55 PM, from the causes and on the date stated above.

SIGNATURE James C. Hellman, Jr., MD ADDRESS Relay Hill Hosp. DATE SIGNED 11/3/56

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL DATE THEREOF 11-7-56 NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL Pk LOCATION (City, town, or county) BALto (State) Md.

DATE REC'D BY LOCAL REGISTRAR 11/8 REGISTRAR'S SIGNATURE — 21. FUNERAL DIRECTOR McCully Funeral Home ADDRESS 130 E. FORT AVE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11116

## CERTIFICATE OF DEATH

11100

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b> c. LENGTH OF STAY IN b <b>132 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>119 W. West Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>ANDREW</b> Middle <b>C.</b> Last <b>PERKINS</b>		4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>1956</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 15, 1893</b>	9. AGE (In years last birthday) yrs. <b>63</b>	IF UNDER 1 YEAR Months <b>63</b>	IF UNDER 24 HRS. Days <b>63</b> Hours <b>63</b> Min. <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>John T. Perkins</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bamford</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> 16. SOCIAL SECURITY NO. <b>218-01-3520</b>		
17. INFORMANT <b>Clinical Records, Veterans Administration Hsp.</b>		Address <b>Ft. Howard, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SQUAMOUS CARCINOMA, LEFT TONSIL</b> DUE TO (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema of lung.</b> <b>Operations 8/8/ &amp; 8/15/56 Removal of tissue from mouth for biopsy.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>VA 19</b>				
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) <b>Baltimore, Maryland</b>		(County) (State)				
21. I certify that I attended the deceased from <b>July 21, 1956</b> to <b>November 30, 1956</b> , and that death occurred at <b>8:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Francis G. Dickey</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> <b>11/30/56</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>FRANCIS G. DICKEY, M.D., Chief, Medical Service</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/3/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Isiah L. Brown &amp; Son Funeral Home, 108 W. Montgomery St., Baltimore 30, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Dec. 3, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farber</b>

U.S. AIR FORCE

1956

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11101

## 11117 CERTIFICATE OF DEATH

Reg. Dist. No. 20

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House In The Pines</u>				STREET ADDRESS (If rural give location) <u>137 Chesterfield Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Margaret</u> (First) (Middle) (Last) <u>Pieger</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>11</u> <u>19</u> <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 20, 1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of done during most of working life, even if retired) <u>Book Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.V.T. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Pieger</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Weindorfer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Elizabeth Bauer 5137 Chesterfield</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1. IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>1 hr.</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-Vascular-Renal Disease</u>						<u>15 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-13</u> , 19 <u>56</u> , to <u>11-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-19</u> , 19 <u>56</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wilmer K. Gallagher</u>				ADDRESS (Street, city, town, state) <u>M.D. 1209 Frederick Rd. Balt. 28, Md.</u>		DATE SIGNED <u>11/20/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 21, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>11-23 56</u>		REGISTRAR'S SIGNATURE <u>Victor C. Garry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home</u>		ADDRESS <u>1210 Belair Road.</u>	

S. A.

W. A.

11118

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown (Rural)</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caswell Nursing Home</u>		d. STREET ADDRESS <u>Steeleford - Rural</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM - THOMAS PITTS</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10 - 1898</u>
9. AGE (In years last birthday) <u>100</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Geo Bolte</u> Address <u>Reisterstown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis, generalized</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart failure.</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 1955</u> , to <u>November 25, 1956</u> , that I last saw the deceased alive on <u>November 25, 1956</u> , and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles E. Williams</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 28/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mr Carmel</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E. Tipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>11-26-56</u>	24b. REGISTRAR'S SIGNATURE <u>Nancy B. Elmer</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low number that this death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

BUREAU V. S.

NOV 28 1956

RECEIVED

NOV 28 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

111119

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

111103

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>SMITH</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt 19</u>			c. LENGTH OF STAY IN 1b <u>SALTVILLE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BETH. STEEL DISPENSARY</u>			d. STREET ADDRESS <u>RURAL</u>		
3. NAME OF DECEASED (Type or print) <u>ROBERT C. POORE</u> First Middle Last			4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1952</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 29, 1924</u> 32 yrs.		9. AGE (in years) (last birthday) <u>32</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEELWORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RIVETER</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>	
13. FATHER'S NAME <u>ROBT. K. POORE</u>			14. MOTHER'S MAIDEN NAME <u>MABEL HURLEY</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>HENDERSON FUNERAL - VA.</u> Address <u>SALTVILLE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell From Height of About 30 Ft.</u>			
20c. TIME OF INJURY Month, Day, Year <u>10:35 P.M.</u> <u>11-15</u> <u>1952</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Steel Plant</u>	
20f. (City or town) <u>Belt Sparrows Pt. Balt Md.</u>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-15-52</u>	
EXAMINER'S NAME (Type) <u>Jack C Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-17-52</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EMMA BETH CEM.</u>	
22d. LOCATION (City, town, or county) <u>SALTVILLE</u>		22e. (State) <u>VA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dawson L. Lark</u>			24a. REC'D BY REGISTRAR <u>Dawson L. Lark</u>		
24b. REGISTRAR'S SIGNATURE <u>Dawson L. Lark</u>			DATE <u>11-15-52</u>		

BUREAU V. S.

NOV 10 1956

RECEIVED

## 10977 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLGATE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLGATE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>521 FAIRVIEW AV</b>				d. STREET ADDRESS <b>521 FAIRVIEW AVE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>LUCY E. POPP</b>				4. DATE OF DEATH Month Day Year <b>NOV 14 1956</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV 18 1885</b>	
9. AGE (In years last birthday) yrs. <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>70</b>		IF UNDER 24 HRS. <b>70</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>OWEN W. WISE</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH RHODENIZER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>—</b>			
17. INFORMANT <b>MRS JAMES LUDWIG</b>				Address <b>521 FAIRVIEW</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Artero-Sclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 years</b> <b>10 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>COLGATE</b>				20g. (County) <b>MD</b>		20h. (State) <b>MD</b>	
21. I certify that I attended the deceased from <b>July 8</b> , 19 <b>55</b> , to <b>Nov 14</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov 14</b> , 19 <b>56</b> , and that death occurred at <b>5 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Morris A. Jacobs</b>				M.D. <b>1010 North Point Rd</b>			
PHYSICIAN'S NAME (Type) <b>MORRIS A. JACOBS</b>				DATE SIGNED <b>Balto 24 Nov</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV 17 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>		22d. LOCATION (City, town, or county) (State) <b>COLGATE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ULLRICH FUNERAL HOME</b>				ADDRESS <b>2112 DUNDON</b>		24a. REC'D BY REGISTRAR <b>16 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Wm. Kelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, which should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

10 10 1956

RECEIVED  
BUREAU V. E.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11120

CERTIFICATE OF DEATH

Reg. Dist. No.

11105

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>408 S. Rolling Rd.</u>				d. STREET ADDRESS <u>408 S. Rolling Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Josephine M. Irssler</u>				4. DATE OF DEATH Month Day Year <u>Nov. 29 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 20, 1889</u>		9. AGE (In years last birthday) yrs <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John W. Kaiserski</u>				14. MOTHER'S MAIDEN NAME <u>Julia Irssler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>9---</u>		17. INFORMANT Address <u>Wilbur G. Irssler 408 S. Rolling Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chronic Congestive Failure</u> DUE TO (c) <u>Coronary artery disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>3 mos</u> <u>? yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10/4</u> , 19 <u>55</u> , to <u>11/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>56</u> , and that death occurred at <u>2<sup>00</sup> PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Victor F. King</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov 30/56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-3-56</u>		<u>Loudon Park Cem</u>		<u>Balto.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Volley Funeral Home - Catonsville Md</u>				24. REC'D BY REGISTRAR DATE <u>DEC 4 1956</u>			
				24b. REGISTRAR'S SIGNATURE <u>P. E. Harvey</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be retained by the hospital or attending physician.

TO PUBLIC HEALTH OFFICE: After this certificate has been signed by the attending physician, it may be retained by the hospital or attending physician. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 5 and 6 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 7 1900

RECEIVED

## 11121 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>11 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>B.</b> Last <b>PRICE</b>				4. DATE OF DEATH Month <b>November</b> Day <b>7,</b> Year <b>19 56</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-13-93</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PIPEFITTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coast Maintenance-Guard</b>			
13. FATHER'S NAME <b>JOHN B. PRICE</b>				14. MOTHER'S MAIDEN NAME <b>LAURA BOWERS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-1</b>				16. SOCIAL SECURITY NO. <b>218-03-7496</b>			
17. INFORMANT <b>VAH, Fort Howard, Md.</b>				Address <b>CLINICAL RECORDS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> DUE TO <b>GENERALIZED ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <b>VA</b> attended the deceased from <b>Oct. 27</b> , 19 <b>56</b> , to <b>Nov. 7</b> , 19 <b>56</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Francis G. Dickey</b> M.D.				ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>FRANCIS G. DICKEY</b> M.D., Chief, Medical Service, Fort Howard, Maryland VAH				DATE SIGNED <b>11/8/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>Nov 12 1956</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>				22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ulrich Funeral Home, 4210 Belair Rd., Balto. Md.</b>				24a. REC'D BY REGISTRAR <b>DATE</b>			
24b. REGISTRAR'S SIGNATURE <b>Lawson D. Fisher</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8 % 00

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11107 41

f. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 22</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>106 Avon Beach Pr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Rufus</u> Middle <u>Andrew</u> Last <u>Price</u>		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/04</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker Bethlehem St. Allegheny Co., Va.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Chas. H. Price</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Lively</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-14-8738</u>	
17. INFORMANT <u>William A. Price, 1830 W. Lanvale St.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>440.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack C Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Allegheny Co., Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Lary, 802 Madison Ave.</u>		24a. REC'D BY REGISTRAR <u>Mr. Kelly</u>	
		24b. REGISTRAR'S SIGNATURE	

THIS CERTIFICATE SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EX-  
CUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, OR 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE  
FORWARDED TO THE CHIEF MEDICAL EXAMINER'S OFFICE ALONG WITH FORM PM-3. PAGE 5 MAY BE RETAINED FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. FILE PAGES 1 AND 2 WITH THE REGISTRY TO BURIAL, CREMATION,  
OR REMOVAL.

BUDGET 1968

NOV 1967

INTECH

11122

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Penn.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>For City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phila.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pulaski Highway</b>		d. STREET ADDRESS <b>1744 N. 15th St.</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>(REDD)</b> Last <b>REDD</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>26</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Separated</b>	8. DATE OF BIRTH <b>12/31/1919</b>
9. AGE (In years last birthday) <b>36</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public</b>	11. BIRTHPLACE (State or foreign country) <b>Rockville, S.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jake Crawford</b>	
14. MOTHER'S MAIDEN NAME <b>Lula Harris</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>191-16-7048</b>		17. INFORMANT <b>Mamie Williams</b> Address <b>728 Shirley St., Phila. Penn.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Skull fracture</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Auto-truck collision</b>	
20c. TIME OF INJURY Month, Day, Year <b>11:30 AM 11/25/ 19 56</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>	20f. (City or town) (County) (State) <b>Balto. Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		DATE SIGNED <b>Nov. 29, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>11/30/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Ray, Phila., Penn.</b>		24a. REC'D BY REGISTRAR <b>Dec 3, 1956</b> 24b. REGISTRAR'S SIGNATURE <i>Mr. Walter H. H. H.</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

DEC 4 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11123

CERTIFICATE OF DEATH

11109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines-16 Fusting Ave.</b>				d. STREET ADDRESS <b>8109 Bellona Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ELSIE</b> Middle <b>S.</b> Last <b>RIEKER</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>22</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 28, 1880</b>	9. AGE (In years last birthday) <b>76</b> yrs	IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>	IF UNDER 24 HRS Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>William Wallace Scharf</b>				14. MOTHER'S MAIDEN NAME <b>(unknown) Wesley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Mr. Marlin W. Brown - 8109 Bellona Ave.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chr. Hypertensive Cordis Vascular Disease</b> DUE TO (c) <b>15 yrs (?)</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10-4</b> , 1955, to <b>11-22</b> , 1956, that I last saw the deceased alive on <b>11-21</b> , 1956, and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6209 Frederick Road</b> DATE SIGNED <b>11/23/56</b> ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b> M.D. PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b> <b>Baltimore-28, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/24/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Stevensville Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Stevensville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William J. Lickner &amp; Sons - Baltimore</b>				24a. REC'D BY REGISTRAR <b>DATE 11-27-56</b>			
24b. REGISTRAR'S SIGNATURE <b>J. E. Harry</b>							

SCHEIDT V. S.

101

101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11124

CERTIFICATE OF DEATH

1111030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. CO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINTHICUM HGTS.</u>			
c. LENGTH OF STAY in 1b <u>LIFE</u>				d. STREET ADDRESS <u>408 HAWTHORNE RD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16 FUSTING AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET RIORDAN</u>				4. DATE OF DEATH Month Day Year <u>NOV 8 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 16, 1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HENRY COLLINS</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>JOHN T. RIORDAN JR, 5101 OAKLAWN RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO <u>Cardiovascular C. V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>June</u> , 1954, to <u>Nov. 8</u> , 1956, that I last saw the deceased alive on <u>Nov. 6</u> , 1956, and that death occurred at <u>1 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. C. MacLaughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>4508 Edmondson Village</u> DATE SIGNED <u>11/10/56</u>			
PHYSICIAN'S NAME (Type) <u>D. C. MacLaughlin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Wight</u> ADDRESS <u>4101 EDMONDSON</u>				24a. REC'D BY REGISTRAR <u>11</u> DATE <u>11/10/56</u>		24b. REGISTRAR'S SIGNATURE <u>F. E. Barry</u>	

EDWARD V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10979

## CERTIFICATE OF DEATH

11111

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK 22</b>				c. LENGTH OF STAY IN 1b <b>40 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK 22</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>73 WILLOW SPRING Rd</b>				d. STREET ADDRESS <b>73 WILLOW SPRING RD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EVA MAE RITCHEY</b>				4. DATE OF DEATH <b>NOV. 15 1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-23-1878</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN UNKAPHER</b>				14. MOTHER'S MAIDEN NAME <b>LUCINDA GIBSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>WICKROSKY</b> Address <b>DUNDALK, MD. 73 WILLOW SPRING RD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>171X DUE TO METASTATIC CARCINOMA OF CERVIX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) <b>3 1/2 YRS</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3 NOV 1956</b> to <b>15 NOV 1956</b> , that I last saw the deceased alive on <b>15 NOV 1956</b> , and that death occurred at <b>5:20 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>DR. W. E. BAERMANN</b>				ADDRESS (Street, city or town, state) <b>33 DUNDALK AVENUE DUNDALK 22, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>DR. W. E. BAERMANN</b>				DATE SIGNED <b>11-15-56</b>			
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF <b>11-19-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE</b>		22d. LOCATION (City, town, or county) (State) <b>DUNDALK 22, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Burke Dudley</b> ADDRESS <b>DUNDALK, MD.</b>				24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. Kelly</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 19 1956

BUREAU V. 2

11125

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11112

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>534 Walker Ave. Drumcastle Apts.</b>			d. STREET ADDRESS <b>534 Walker Ave. Drumcastle Apts.</b>		
3. NAME OF DECEASED (Type or print) <b>EDNA M. RITTER</b>			4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov : 3 : 1900</b>		9. AGE (In years last birthday) <b>56</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sherwood Oil Company</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
13. FATHER'S NAME <b>George A. Ritter</b>			14. MOTHER'S MAIDEN NAME <b>Caroline Koch</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>216-05-2351</b>		17. INFORMANT <b>Howard Ritter</b> Address <b>625 Murdock Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV:21-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. B. Wipperfurth</b>		ADDRESS <b>1300 Eutaw Place</b>		24a. REC'D BY REGISTRAR <b>DATE 11-23-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the date of this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1956



## 11126 CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4209 Fitch Ave.				d. STREET ADDRESS 4209 Fitch Ave.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Rohe		4. DATE OF DEATH Month Day Year November 20, 1956					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1885	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Rohe				14. MOTHER'S MAIDEN NAME Ellen Dougherty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 213-36-8012		17. INFORMANT Address Mrs. Mary M. Rohe 4209 Fitch Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH 1 week 6 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 Nov.</u> , 19 <u>56</u> , to <u>20 Nov.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>20 Nov.</u> , 19 <u>56</u> , and that death occurred at <u>11 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>6801 Belair Rd. Balto. Md. 6-21-56</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Fullerton, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lessaugh Funeral Home</u>				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE <u>11-23-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. A. P. Reifsnider</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## 11127 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery Co</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. STREET ADDRESS <b>503 Homer Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>Lebert</b> Last <b>Roman</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-9-1883</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min <b>00</b>	
11. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>D.C. Unemployment Compensation Bd.</b>		12. KIND OF BUSINESS OR INDUSTRY <b>retired since 1952</b>	
13. FATHER'S NAME <b>John A. Roman</b>		14. MOTHER'S MAIDEN NAME <b>Emma Gregory</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>579-01-9528</b>	
17. INFORMANT <b>Hospital records</b>		18. ADDRESS <b>Mt. Wilson State Hospital</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiectasis, fibrotic pne-</b> DUE TO <b>monary, intercurrent, bilateral.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Auricular fibrillation</b> DUE TO (c) <b>Auricular fibrillation</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Auricular fibrillation</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-8-52</b> , 19 <b>53</b> , to <b>Nov 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 17</b> , 19 <b>58</b> , and that death occurred at <b>10:30</b> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>William Newcomer</b>			
22. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
22b. DATE THEREOF <b>Nov. 21, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>		22e. REGISTRAR'S SIGNATURE <b>William Newcomer</b>	
22f. REGISTRAR'S SIGNATURE <b>William Newcomer</b>		22g. REGISTRAR'S SIGNATURE <b>William Newcomer</b>	

VS 15M 9/35 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11128 CERTIFICATE OF DEATH

11115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>				c. LENGTH OF STAY IN 1b <b>54</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>505 Dorsey Ave.,</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>			
d. STREET ADDRESS <b>505 Dorsey Ave.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Charles A. Sauer Jr.,</b>				4. DATE OF DEATH Nov. 4th, 1956			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 21st, 1876</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Crown Cork &amp; Seal</b>			
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Charles A. Sauer, Sr.,</b>				14. MOTHER'S MAIDEN NAME <b>Mary</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-03-1634</b>			
17. INFORMANT <b>Mrs Bessie Sauer (Wife) Above</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage. Jackson-type of epilepsy.</b> DUE TO <b>Tumor of the brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis.</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>15 months</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>September, 1955</b> to <b>11-4</b> 19 <b>56</b> , that I last saw the deceased alive on <b>September, 1956</b> , and that death occurred at <b>11:45</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>413 Eastern Ave, Essex, Md</b> DATE SIGNED <b>11-5-1956</b> ACTUAL SIGNATURE <b>Eugene C. Baumann</b> M.D. PHYSICIAN'S NAME (Type) <b>Eugene C. Baumann</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov 7th, 1956</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Eastern Blvd. Balto, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly</b>				24a. REC'D BY REGISTRAR <b>NOV 7 1956</b>			
ADDRESS <b>18 Eastern Blvd Essex</b>				24b. REGISTRAR'S SIGNATURE <b>Edith Hurlay</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11129 CERTIFICATE OF DEATH

11116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines - 16 Fasting Ave.</b>				d. STREET ADDRESS <b>3036 Edmondson Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>E.</b> Last <b>SCHIEB</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>15,</b> Year <b>19 56</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 3, 1879</b>		9. AGE (In years last birthday) <b>77</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Edu. Balto.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Harry A. Scheib</b>				14. MOTHER'S MAIDEN NAME <b>Mary L. Sexton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. John L. Scheib - Cedar Rd., Littleton, Mass.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease &amp; Cerebral Vascular Sclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN. 17, 1955</b> , to <b>Nov. 15, 1956</b> , that I last saw the deceased alive on <b>Nov. 14, 1956</b> , and that death occurred at <b>7:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Harry L. Knipp, M.D.</b>		ADDRESS (Street, city or town, state) <b>4116 Edmondson Ave Baltimore 29 Maryland</b>		DATE SIGNED <b>11/16/56</b>			
PHYSICIAN'S NAME (Type) <b>HARRY L. KNIPP M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/19/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto 17th</b>				ADDRESS <b>BALTO 17th</b>		24a. REC'D BY REGISTRAR DATE <b>Nov 19 56</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. B. Harry</b>			

U. S. AIR FORCE

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11130 CERTIFICATE OF DEATH

Reg. Dist. No.

11113

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Old Court Rd.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>			
				d. STREET ADDRESS <b>Waldron Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>Charles William Schildwachter</b>				4. DATE OF DEATH Month <b>11</b> , Day <b>7</b> , Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1886</b>	9. AGE in years (last birthday) <b>70</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Schildwachter</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Peters</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>217-07-4659</b>		17. INFORMANT Address <b>Howard H. Schildwachter, Pikesville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Myocarditis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/1/1956</b> to <b>11/7/1956</b> that I last saw the deceased alive on <b>11/5/1956</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm. E. Martin</b>				ADDRESS (Street, city or town, state) <b>Randallstown Md.</b>			
PHYSICIAN'S NAME (Type) <b>W. E. MARTIN</b>				DATE SIGNED <b>11-7-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-9-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Kriders Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b>				ADDRESS <b>Pikesville, Md.</b>		24a. REC'D BY REGISTRAR <b>11-13-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Lorothy Newell</b>			

NOV 13



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-10. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

10988 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11118  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

42

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto Highland</u>		c. LENGTH OF STAY IN 1b <u>5 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto Highland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2806 Belmore Ave</u>				d. STREET ADDRESS <u>2806 Belmore Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louis W Schmidt</u>				4. DATE OF DEATH Month Day Year <u>Nov 26 19 56</u>			
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15 1875</u>		9. AGE (In years, last birthday) yrs. Months Days	IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Copper Smith</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sugar refinery</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
13. FATHER'S NAME <u>Louis W Schmidt</u>				14. MOTHER'S MAIDEN NAME <u>Louise F. Schmidt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Elizabeth Schmidt</u>		Address <u>2806 Belmore Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO (b) <u>Extensive vascular disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>General Arterio sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov. 26 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 27 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Walters</u>				ADDRESS <u>1414 E. St. Baltimore</u>		24a. REC'D BY REGISTRAR <u>Dr. Geo. M. Kieffer</u>	
				24b. REGISTRAR'S SIGNATURE			

U. S. A. 1914

1914

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11131 CERTIFICATE OF DEATH

11119

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>617 Edmondson Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gretchen Anna Schwarz</u>			4. DATE OF DEATH Month Day Year <u>Nov. 29, 1956</u>				
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1897</u>		9. AGE (In years last birthday) <u>59</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Gentsch</u>				14. MOTHER'S MAIDEN NAME <u>Anna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Charles F. Schwarz, 617 Edmondson Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL CEREMIA</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PNEUMONITIS - DEHYDRATION</u> DUE TO (c) <u>HODGKINS DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/1</u> , 1956, to <u>11/29</u> , 1956, that I last saw the deceased alive on <u>11/27</u> , 1956, and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D.				ADDRESS (Street, city or town, state) <u>6800 Edmondson Ave</u>			
PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>				DATE SIGNED <u>Dec. 28, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation Dec. 5, 1956</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. White</u>				ADDRESS <u>4101 Edmondson Ave</u>		24. REC'D BY REGISTRAR DATE <u>DEC 3 1956</u>	
				25. REGISTRAR'S SIGNATURE <u>L. E. Barry</u>			

U. S. A.

1950

may be obtained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Filed 11-13-56 at

## CERTIFICATE OF DEATH

11132

11120

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 302 Ridge Rd.</u>				d. STREET ADDRESS <u>Box 302 Ridge Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>John Henry Seifert</u>				4. DATE OF DEATH <u>Nov 5 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1888</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Florist</u>		11. BIRTHPLACE (State or foreign country) <u>Balto, Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Otto Seifert</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Deigert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>August J. Seifert</u>		Address <u>Box 302 Ridge Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular disease</u> DUE TO (c) <u>2 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 5 1956</u> to <u>Nov 5 1956</u> that I last saw the deceased alive on <u>Nov 5 1956</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Baumgardner</u> M.D.				ADDRESS (Street, city or town, state) <u>Balto G Md</u>			
DATE SIGNED <u>11/5/56</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 8, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Belair Rd. Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cassam Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>Nov 7 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mr. A. L. Hoffmann</u>			

BUREAU V. 8

OV 7 1956

RECEIVED



11133

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
c. LENGTH OF STAY IN 1b <b>42 DAYS</b>				d. STREET ADDRESS <b>902 WALNUT AVE ZONE 29</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ALBERT</b>		First Middle Last		4. DATE OF DEATH <b>NOV 29 1956</b>		Month Day Year	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 18, 1867</b>		9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BAKERY</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PAUL SEILER</b>				14. MOTHER'S MAIDEN NAME <b>not known</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218 22 6507</b>		17. INFORMANT <b>Alma Berkenkemper 902 Walnut Ave. (daughter)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>OCT 19, 1956</b> to <b>NOV 29, 1956</b> that I last saw the deceased alive on <b>NOV 29, 1956</b> at <b>7:45 P M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>11-30-56</b>					
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>DEC. 3 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LAWSON PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. on Type 4101 Edmondson ave</b>				24a. REC'D BY REGISTRAR <b>DEC 3 1956</b>		24b. REGISTRAR'S SIGNATURE <b>P. E. Harry</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

REC 1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11122

1-11341 3/12/56 GE

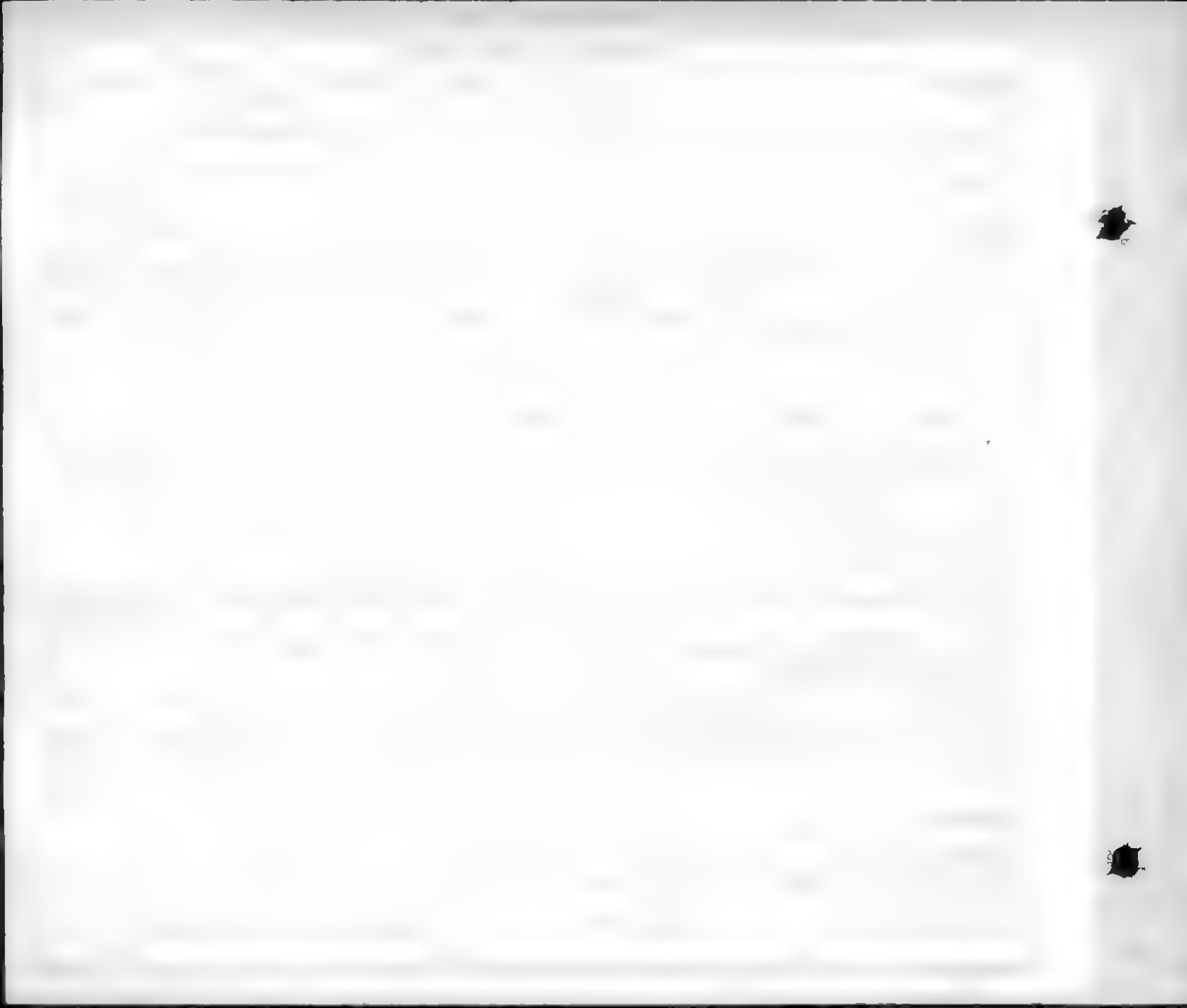
1. NAME OF DECEASED (Type or Print) <b>MARIA SERNOCKY</b>		2. DATE OF DEATH <b>11/12/56</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>130 N. Lynnington Ave</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 28</b>	
C. Length of stay in Baltimore <b>43</b> Yrs. Mos. Days <b>130 N. Lynnington Ave</b>		D. STREET ADDRESS (If rural, give location)	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb 2, 1896</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		9. AGE (In years last birthday) <b>61</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>	
13. FATHER'S NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronaries occlusion</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Chronic heart failure</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Hypertension &amp; arteriosclerosis</b>		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>July 15, 1956</b> to <b>Nov. 12, 1956</b> that I last saw the deceased alive on <b>11/13, 1956</b> and that death occurred at <b>5:30 a.m.</b> from the causes and on the date stated above.				
23A. SIGNATURE <b>Stanley Ankus</b>		23B. ADDRESS <b>1803 W. Baltimore St.</b>		23C. DATE SIGNED <b>11/15/56</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>11/15/56</b>	24C. NAME OF CEMETERY OR CREMATORY <b>West Holy Redeemer</b>	24D. LOCATION (City, town, or county) (State) <b>Belair Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>Nov 15 1956</b>		REGISTRAR'S SIGNATURE <b>Charles W. Schaubert</b>		25. FUNERAL DIRECTOR'S ADDRESS <b>103 McHenry St</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 11135 CERTIFICATE OF DEATH

Reg. Dist. No.

39

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phoenix Rd</i>		d STREET ADDRESS <i>Phoenix Rd</i>	
3. NAME OF DECEASED (Type or print) <i>John William Shaffer</i>		4. DATE OF DEATH <i>November 12 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 19 1888</i>
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-20-8644A</i>	
17. INFORMANT <i>Mrs Raymond Dorit</i> Address <i>Phoenix, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> <i>422.1</i> DUE TO <i>Arteriosclerotic cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO <i></i> (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 wks</i> <i>unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct 1956</i> to <i>Nov 1956</i> , that I last saw the deceased alive on <i>11 Nov 1956</i> , and that death occurred at <i>2 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i>		ADDRESS (Street, city or town, state) <i>Cockeysville, Md</i> DATE SIGNED <i>12 Nov 56</i>	
PHYSICIAN'S NAME (Type) <i>Walter T. KEES</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-15-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Poplar Grove</i>	22d. LOCATION (City, town, or county) (State) <i>Cockeysville, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Scott Brooks, Sparks, Md</i> ADDRESS		24a. REC'D BY REGISTRAR <i>Nov. 16, 56</i> 24b. REGISTRAR'S SIGNATURE <i>M. Elizabeth Groul</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be assigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~feeder~~ papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 7 1956

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11136 CERTIFICATE OF DEATH

11124

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>(NMI)</b> Last <b>SHIELDS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/16/91</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>		11. BIRTHPLACE (State or foreign country) <b>Cambridge, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM SHIELDS</b>				14. MOTHER'S MAIDEN NAME <b>MARY BANKS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>219-20-9724</b>		17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF THE RECTUM WITH METASTASES</b> <b>154x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 21, 19 56</b> , to <b>November 24, 19 56</b> , that I last saw the deceased alive on <b>November 24, 19 56</b> , and that death occurred at <b>2:25 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Veterans Administration Hospital 11/25/56</b>							
ACTUAL SIGNATURE <b>C. J. Papastrat</b>				M.D. <b>Veterans Administration Hospital 11/25/56</b>			
PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>				Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/28/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHARLES R. LAW</b>				ADDRESS <b>MORTUARY 802-OL MADISON AVE. BALTIMORE</b>		24a. REC'D BY REGISTRAR <b>11/28/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Lawrence R. Fortney</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED A. M.

1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11137 CERTIFICATE OF DEATH

11125

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2115 Holder Ave</u>				d. STREET ADDRESS <u>406 Mt. Holly St.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>Slemaker</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>19 56</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 21, 1875</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer, Balto. Copper Paint Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>213-01-8650</u>		17. INFORMANT <u>Mrs Janet Jones, 215 Holder Ave, Woodlawn.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>leuremia</u> <u>446X</u> DUE TO <u>Prostatitis &amp; c. suppuris</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis &amp; hypertension</u> DUE TO (c) <u>Prostatectomy Oct 1956</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatectomy Oct 1956</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>2 yrs.</u> <u>10 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 1955</u> to <u>Nov 25, 1956</u> that I last saw the deceased alive on <u>Nov 24</u> <u>19 56</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4100 Edmondson Ave</u> DATE SIGNED <u>Dr. Wm. M. Martin</u> ACTUAL SIGNATURE <u>Dr. C. Wells</u> M.D. <u>4100 Edmondson Ave</u> PHYSICIAN'S NAME (Type) <u>Dr. C. Wells</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witte</u> ADDRESS <u>4101 Edmondson Ave.</u>				24a. REC'D BY REGISTRAR <u>Nov. 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. M. Martin</u>	

BUREAU V. E.

NOV 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11138 CERTIFICATE OF DEATH

11126 28

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3527 Edoppa Rd.</u>		d. STREET ADDRESS <u>3527 Edoppa Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER</u> First <u>E</u> Middle <u>SMALLWOOD</u> Last		4. DATE OF DEATH Month <u>Nov</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 26-1894</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Smallwood.</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA McDonald</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>FANNIE R. Smallwood</u> Address <u>3527 E Joppa Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myo-Carditis + Endocarditis</u> DUE TO <u>Chronic Pulmonary + Abdominal Tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>General Arterio Sclerosis</u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>year</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Nov 26</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>56</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert M. Foster</u> M.D. <u>2824 ST. Paul</u>		DATE SIGNED <u>Nov 27, 56</u>	
PHYSICIAN'S NAME (Type) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/28/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F Evans &amp; Son</u> ADDRESS <u>8802 Hartford Rd</u>		24. REC'D BY REGISTRAR <u>  </u> DATE <u>29 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11:39 CERTIFICATE OF DEATH

11127

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Catonsville Convalescent Home</u>				d. STREET ADDRESS <u>3019 Balder Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>SMELSER</u> Last <u>SMELSER</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31, 1898</u>		9. AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Alexander. Slaysman</u>				14. MOTHER'S MAIDEN NAME <u>-- Slaysman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Mrs. Hazel G. Birnie - 25 Gwynn Lake Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis (bulbar)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>Arterio sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>96 hrs</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u>a. p.</u> Month <u>  </u> Day <u>19</u> Year <u>  </u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-17</u> , 19 <u>56</u> , to <u>11-2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-2</u> , 19 <u>56</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen Lee Magness</u> M.D.				ADDRESS (Street, city or town, state) <u>908 Frederick St. Catonsville</u>			
DATE SIGNED <u>11-3-56</u>							
PHYSICIAN'S NAME (Type) <u>STEPHEN LEE MAGNESS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Schuler &amp; Sons - Balto 17th St.</u>				ADDRESS <u>BALTO 17th St.</u>		24a. RECEIVED BY REGISTRAR DATE <u>Nov. 5 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>F. E. Murray</u>			

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NOV 7

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the funeral home, or the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 11128

11140

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY OR TOWN <u>Butler</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Falls Rd</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY OR TOWN <u>Butler</u> STREET ADDRESS <u>Falls Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Margaret Ethel Smith</u>		4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>27</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>17 Sept 1892</u>
9. AGE last birthday <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Cockeysville, Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Talbot Davenport</u>		14. MOTHER'S MAIDEN NAME <u>Elyza Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT & ADDRESS <u>Daughter - Same address</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>16 weeks</u>	
IMMEDIATE CAUSE (A) <u>Cancer left breast</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>  </u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>  </u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>  </u>			
19a. DATE OF OPERATION <u>  </u>		19b. MAJOR FINDINGS OF OPERATION <u>  </u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>  </u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>  </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>  </u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR? <u>  </u>			
22. I hereby certify that I attended the deceased from <u>19 Nov 56</u> to <u>27 Nov 56</u> , that I last saw the deceased alive on <u>1 Nov 56</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Margaret E. Smith</u>		DATE SIGNED <u>27 Nov 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 30/56</u>	
24. REC'D BY REGISTRAR <u>Mary B. Eline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline</u>	
26. REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		27. ADDRESS (Street, city, town, state) <u>Cockeysville Md</u>	
28. DATE <u>11-28-56</u>		29. LOCATION (City, town, or county) (State) <u>Baltimore County Md</u>	





## 11141 CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Villa Maria, Notch Cliff</u> <u>Baltimore County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Villa Maria</u>		d. STREET ADDRESS <u>Glenarm Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Sister Mary Nativity Spencer</u>		4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Milltown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Schumacher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sr. Mary Clara Notch Cliff, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Osteo Sarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September</u> , 19 <u>46</u> , to <u>November</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 8</u> , 19 <u>56</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>7501 York Rd. Towson, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Charles F. O'Donnell</u>		DATE SIGNED <u>11/10/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>11-12-56</u>	<u>VILLA MARIA CEM.</u>	<u>NOTCH CLIFF NR TOWSON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Gailer</u>		24a. REG'D BY REGISTRAR <u>Nov. 13, 1956</u>	
ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Matel Kray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed with the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: Page 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE A. J. J. J. J.

17-10-1953

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11142 CERTIFICATE OF DEATH

11130 *44*

Reg. Dist. No.

<b>1 PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY</span>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>6 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2547 Fleet Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3 NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <b>MARTIN</b></span> <span>Middle</span> <span>Last <b>STEFANSKI</b></span> </div>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>Month <b>November</b></span> <span>Day <b>15</b></span> <span>Year <b>1956</b></span> </div>									
<b>5 SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>October 13, 1896</b>		<b>9. AGE</b> (In years last birthday) yrs. <b>60</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min		<b>IF UNDER 24 HRS</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Brewery</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Poland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>Thomas Stefanski</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Cecelia Wozniak</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input checked="" type="checkbox"/> <b>WW I</b>				<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> Address <b>Clinical Records, Vet. Adm. Hosp., Ft. Howard, Md.</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS OF LIVER</b>  <b>587.1 DUE TO</b>  <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;">           Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.         </div> <div style="width: 40%;">           (b) _____            DUE TO _____            (c) _____         </div> </div> </div>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 YEARS</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>GASTROINTESTINAL HEMORRHAGE - Duration 4 Weeks</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that</b> <i>X</i> <b>attended the deceased from</b> <b>November 9, 1956, to November 15, 1956</b> , <b>that I last saw the deceased</b> <b>on</b> <b>November 15, 1956</b> , <b>and that death occurred at</b> <b>12:25 P</b> , <b>M.</b> <b>from the causes and on the date stated above.</b> <div style="display: flex; justify-content: space-between;"> <div> <b>ACTUAL SIGNATURE</b>  <i>[Signature]</i>  <b>PHYSICIAN'S NAME (Type)</b> <b>WALTER PIJANOWSKI, M.D.</b> </div> <div> <b>M.D.</b> <b>VAH, FORT HOWARD, MARYLAND</b> </div> <div> <b>DATE SIGNED</b>  <b>11/16/56</b> </div> </div>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>11-19-56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Lawn Cemetery</b>				<b>22d. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles S. Zeiler Funeral Home, 901 S. Conkling</b>						<b>ADDRESS</b> <b>Baltimore, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>11-19-56</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

24 1956

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1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10989 CERTIFICATE OF DEATH

11131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>1.</u> b. COUNTY <u>5.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Robert</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Robert</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1000 1st St. N.E.</u>		d. STREET ADDRESS <u>1000 1st St. N.E.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John William Stevens</u>		4. DATE OF DEATH Month Day Year <u>November 20, 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1892</u>
9. AGE (In years last birthday) yrs. <u>58</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John L. Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. M. Stevens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-01-4321</u>	
17. INFORMANT <u>Mrs. Henrietta Stevens</u>		Address <u>908 Leeds Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>+ 100%</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Coronary Arteritis</u> DUE TO (c) <u>Essential Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>6 yrs</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>50</u> , to <u>Nov 20</u> , 19 <u>50</u> that I last saw the deceased alive on <u>Nov 18</u> , 19 <u>50</u> , and that death occurred at <u>7 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl Pass</u>		DATE SIGNED <u>Nov 21-50</u>	
PHYSICIAN'S NAME (Type) <u>I. EARL PASS MD</u>		ADDRESS <u>4001 WILKENS AVE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/24/50</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>11/23/50</u>		24. REGISTRAR'S SIGNATURE <u>Dr. W. M. Huffer</u>	

RECEIVED  
JUN 1 1956  
BUREAU Y. E.

## 11143 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suthermble</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eccleston</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES MORTON STEWART</u> First Middle Last		4. DATE OF DEATH <u>NOV 13</u> 19 <u>56</u> Day Month Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10 1870</u> 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Morton Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Surman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Charles Morton Stewart Jr. Anne</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHR. CARDIOVASCULAR DISEASE, Arteriosclerosis</u> 420.1 DUE TO <u>CARDIAC Failure (decompensation)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>CEREBRAL VASCULAR Accident</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT. 26</u> 19 <u>56</u> , to <u>NOV 13</u> 19 <u>56</u> , that I last saw the deceased alive on <u>NOV 13</u> 19 <u>56</u> , and that death occurred at <u>3:20</u> P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Hugh G. Whitehead</u> M.D.		ADDRESS (Street, city or town, state) <u>1201 N. Calvert St. Balt. Md.</u> DATE SIGNED <u>11-14-56</u>	
PHYSICIAN'S NAME (Type) <u>Hugh G. Whitehead</u> M.D.		1201 North Calvert Street, Baltimore, Md. 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>NOV 15 / 56</u>	<u>ST. THOMAS</u>	<u>GORELSON FOREST</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Jenkins</u> ADDRESS <u>Sow Co 4905 York Rd</u>		24a. REC'D BY REGISTRAR DATE <u>11-14-56</u> 24b. REGISTRAR'S SIGNATURE <u>Anne MacRae</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 16 1956  
BUREAU OF



11144

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>Rural; Towson</u>				<u>Lutherville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Eudowood Sanatorium</u>		STREET ADDRESS		(If rural give location)	
<u>Towson 4, Maryland</u>				<u>17 Seminary Ave.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
<u>Mary</u>		<u>Margaret</u>		<u>Stoen</u>		<u>Nov 6 1956</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>F</u>		<u>W</u>		<u>married</u>		<u>Feb 5, 1904</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>nurse Rn</u>						<u>BALTO Md</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John La Motte</u>				<u>Ida Johnston</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>?</u>		<u>Personal History</u> <u>Hospital Records, Eudowood Sanatorium</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p><u>14 + X</u> Immediate cause (a) <u>Carcinoma of the soft palate with</u> DUE TO</p> <p>Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>metastasis to glands on both sides of the</u> DUE TO</p> <p>(c) <u>neck and to the base of the palate</u></p>		<u>1948</u>  <u>8 yrs</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:		20. AUTOPSY?
19b. MAJOR FINDINGS OF OPERATION		Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
SUICIDE		HOMICIDE		OF INJURY					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?					
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							

22. I hereby certify that I attended the deceased from Feb 5, 1956, to Nov 6, 1956, that I last saw the deceased alive on Nov 6, 1956, and that death occurred at 12 45 PM, from the causes and on the date stated above.

SIGNATURE Milton B. Kues ADDRESS Eudowood Sanatorium - Towson 4, Maryland DATE SIGNED 11/7/56

23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>11-8-56</u>		<u>Black Rock</u>		<u>Becker, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>11/7/56</u>		<u>Mabel C. Gray</u>		<u>Brooks Funeral Service, Sparks, Md.</u>		<u>J. Scott Brooks</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11134

## 11145 CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4208 Baltimore St.</u>		e. STREET ADDRESS <u>4208 Baltimore St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E. Stoneriver</u> Last <u>Stoneriver</u>		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>Female</u> COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6. DATE OF BIRTH <u>June 12, 1869</u>	9. AGE (In years last birthday) <u>87</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Dyersburg, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Dr. Crayton D. Stoneriver</u>		Address <u>4208 Balto. St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 DUE TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - MYOCARDIAL INFARCTION</u> (c) <u>DISEASE - PULMONARY EMBOLISM</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0. 11.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/11/55</u> , 19 <u>55</u> , to <u>11/4/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/3/56</u> , 19 <u>56</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D.		5800 EDWARDS AVE. 4/1/56	
PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW M.D.</u>		<u>DACT. 28, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11/7/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>	22d. LOCATION (City, town, or county) (State) <u>Potomac Highway Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Shaw</u>		ADDRESS <u>4208 Baltimore St.</u>	24a. REC'D BY REGISTRAR DATE <u>11/4/56</u>
		24b. REGISTRAR'S SIGNATURE <u>John H. Shaw</u>	

11

NOV 7 1950

RECEIVED  
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UNIVERSITY OF MICHIGAN

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1811135

## 11145 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 31

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Balto.</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto 7</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 7.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7017 Queen Anne Rd</u>				d. STREET ADDRESS <u>7017 Queen Anne Rd.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>PHILLIP</u> <u>STROHECKER</u>				<b>4. DATE OF DEATH</b> <u>Nov. 20</u> <u>1956</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>Dec 5, 1889</u>		<b>9. AGE</b> (In years last birthday) <u>66</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Transfer - Sanitary Dept. City Sanitation</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Balto.</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>W.S.A.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>W.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>John Strohecker</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Katherine Scholte</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>no.</u>		<b>17. INFORMANT</b> <u>anna Strohecker (husband)</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive C-V. Disease.</u> (b) _____ (c) _____							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>no.</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>none</u> 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>none</u>			
<b>20f. (City or town)</b> <u>Balto.</u>		<b>20g. (County)</b> <u>Balto.</u>		<b>20h. (State)</b> <u>Md.</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <u>D. D. Caples,</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME</b> (Type) <u>D. D. CAPLES</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>11-20-56</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11/24/1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cemetery</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>Baltimore, Md.</u>		<b>22e. (State)</b> <u>Md.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ellsworth Armacost</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DATE 26 1956</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. M. Martin</u>				<b>24c. (City or town)</b> <u>Balto.</u>			

W. A. R. 1956

1956

W. A. R. 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11147

## CERTIFICATE OF DEATH

11136

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>28 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>505 Cumberland Street</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>A</b> Last <b>STUBES</b>				4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/22/86</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Drug Store</b>		11. BIRTHPLACE (State or foreign country) <b>Hoopersville, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James Stubbs</b>				14. MOTHER'S MAIDEN NAME <b>Willie Travers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-I</b>				16. SOCIAL SECURITY NO. <b>217 01 9850</b>		17. INFORMANT Address <b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE PROSTATE WITH GENERALIZED METASTASIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>VA</b> Hour <b>11</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>October 4, 1956</b> , to <b>November 1, 1956</b> , and that death occurred at <b>12:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Md.</b> DATE SIGNED <b>11/2/56</b> ACTUAL SIGNATURE <b>C. J. Papastrat</b> M.D. PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law Mortuary, 802-04 Madison Ave., Baltimore 1, Md.</b>				24a. REC'D BY REGISTRAR <b>NOV 7 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Rawson L. Farkes</b>			

MEDICAL CERTIFICATION

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If no information, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7621 Bellona Avenue</u>		d. STREET ADDRESS <u>7621 Bellona Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Roberta Sullivan</u>		4. DATE OF DEATH Month Day Year <u>November 27th 19 56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21, 1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Garrett Sullivan</u> Howard		14. MOTHER'S MAIDEN NAME <u>Mary Akehurst</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Paul T. Parrish</u>		Address <u>7621 Bellona Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Sclerosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Chronic myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1951</u> <u>1951</u> <u>1948</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 22, 1956</u> to <u>Nov. 27, 1956</u> that I last saw the deceased alive on <u>Nov. 27, 1956</u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Brown</u>		DATE SIGNED <u>11/28/56</u>	
PHYSICIAN'S NAME (Type) <u>Paul Brown, M.D.</u>		ADDRESS (Street, city or town, state) <u>3627 Liberty Hyg. av. Balto - 15 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/1/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stone Chapel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR DATE <u>12 3</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Ruck</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
DEC 8 1964

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## 10980 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1762 Brookview Rd</u>		STREET ADDRESS (If rural, give location) <u>1762 Brookview Rd</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Anthony M. Swiderski</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 2 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan 14 1884</u>
9. AGE last birthday <u>72</u> yrs.		10. AGE last birthday If under 1 year: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>New York Buffalo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Swiderski</u>		14. MOTHER'S MAIDEN NAME <u>Mary Janka</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>214-01-7782</u>	
17. INFORMANT AND ADDRESS <u>Anthony T. Swiderski 1762 Brookview Rd</u>			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Carcinoma of the Pancreas

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

4 Mo

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov 2, 1956, to Nov 2, 1956, that I last saw the deceasedalive on Nov 2, 1956, and that death occurred at 2:45 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

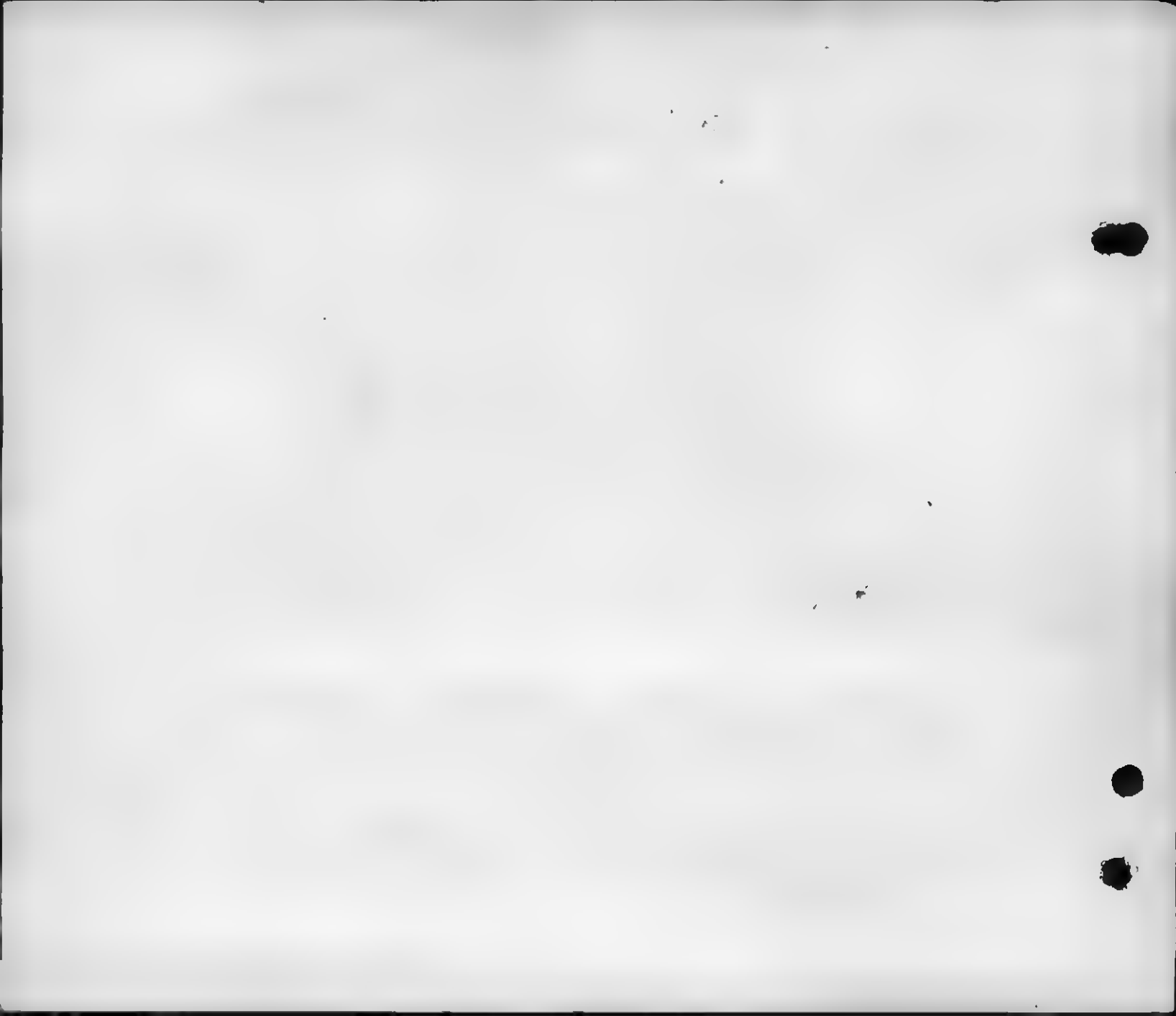
J. J. C. Mockaitis M.D. 6714 Holmdel Ave11-2-56

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Nov 5-56</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u>	LOCATION (City, town, or county) (State) <u>German Hill Rd. Balto. Co. Md</u>
DATE REC'D BY LOCAL REG. <u>Nov 8, 1956</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>W. J. Pappas</u>	ADDRESS <u>1800 E. Lombard St</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 11149 CERTIFICATE OF DEATH

Reg. Dist. No.

20

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>d.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Home</u>		d. STREET ADDRESS <u>111 S. Warwick Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jennie D. Tarring</u>		4. DATE OF DEATH Month Day Year <u>Nov. 1, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1869</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New London, Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Otis Dimock</u>		14. MOTHER'S MAIDEN NAME <u>Harriet D. Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>101-10-10000</u>	
17. INFORMANT <u>Oliver Tarring</u>		Address <u>111 S. Warwick Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO (b) <u>General Arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 19 <u>48</u> to <u>Nov 1</u> , 19 <u>56</u> that I last saw the deceased alive on <u>11/1</u> , 19 <u>56</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel P. Placencia</u> M.D.		ADDRESS (Street, city or town, state) <u>3326 Funderburg St.</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/3/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edison Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. ...</u>		ADDRESS <u>107 Wilkens Avenue</u>	24a. RECEIVED BY REGISTRAR <u>Nov 5, 1956</u>
			24b. REGISTRAR'S SIGNATURE <u>T. E. Harris</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 TOWSON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>410 VIRGINIA AVE.</b>		d. STREET ADDRESS <b>410 VIRGINIA AVE</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>HENRY</b> Last <b>THOMAS</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>10</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/79</b>
9. AGE (In years lost birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>FANNY THOMAS</b>		Address <b>410 VIRGINIA AVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>42d.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>4 YRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>AUG. 1956</b> to <b>NOV. 10 1956</b> , that I last saw the deceased alive on <b>NOV. 10 1956</b> , and that death occurred at <b>9:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>TOWSON, MD</b> DATE SIGNED <b>11/10/56</b> ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D. <b>WILLIAM A. PILLSBURY</b> PHYSICIAN'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/14/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WILSON</b>	22d. LOCATION (City, town, or county) (State) <b>TOWSON, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. C. Glatman</b>		24a. REC'D BY REGISTRAR <b>11-1-56</b>	24b. REGISTRAR'S SIGNATURE <b>Wm. C. Glatman</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

U. S. A.





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11141**  
**11151 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **85**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monkton (rural)</b>		c. LENGTH OF STAY IN life <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monkton (rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Big Falls Rd.</b>			d. STREET ADDRESS <b>Big Falls Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Leonard Lee</b> Middle <b>Thomas</b> Last <b>THOMAS</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>3</b> Year <b>1956</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-19-56</b>	9. AGE (In years last birthday) Yrs. <b>2</b> Mos. <b>15</b> Days <b>15</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>York, Penn.</b>	
13. FATHER'S NAME <b>Jack Hobert Thomas</b>			14. MOTHER'S MAIDEN NAME <b>Loretta Ridley</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Hobert Thomas, Monkton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>other</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____	(County) _____	(State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>G. M. France</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>A. M. FRANCE</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-4-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Jessops Methodist</b>	
				22d. LOCATION (City, town, or county) <b>Sparks, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>I Scott Brooks</b>		ADDRESS <b>Sparks, Md.</b>		24a. REC'D BY REGISTRAR <b>3 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chestnut L. Lutter</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. P.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/55

MARYLAND-STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Baltimore City Health Department

CERTIFICATE OF DEATH

11152

11142

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6212 Frankford Avenue</u>				d. STREET ADDRESS <u>6212 Frankford Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mr. Robert</u> Middle <u>Tilford</u> Last <u>Tilford</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 13, 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>							
13. FATHER'S NAME <u>John Tilford</u>				14. MOTHER'S MAIDEN NAME <u>  </u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>213-07-4576</u>		17. INFORMANT Address <u>Mrs. Grace B. Tilford, 6212 Frankford</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tumor of the Brain</u>							
DUE TO (b) <u>None</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>Oct. 15, 1956</u> to <u>Nov 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 12</u> , 19 <u>56</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>6210 York Road, Baltimore, 12, Md.</u>				DATE SIGNED <u>Nov. 20, 1956</u>			
ACTUAL SIGNATURE <u>A.S. Chaffant</u>				M.D. <u>  </u>			
NAME (Type) <u>A. S. Chaffant</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Enola, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard G. Ruck</u> ADDRESS <u>5305 Hargard Road #14</u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>Nov. 20, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. J. M. Bacon</u>	

NO. 4

1956

10/1/56

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11153 CERTIFICATE OF DEATH

11143 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>				c. LENGTH OF STAY IN 1b <b>6 wks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armacest Nursing Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>			
				d. STREET ADDRESS <b>4404 Rokeby Rd.</b>			
3. NAME OF (Type or print) <b>Caroline A. Tillery</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>13</b> Year <b>19 56</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 18, 1887</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Theodore Loose</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address <b>Mrs Paul L. Falkemor, 4404 Rokeby Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Phenobarbital Intoxication</b> DUE TO <b>Asystole Secondary to U.D. Disease</b> (c) <b>Coronary Sclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 1955</b> to <b>Nov 13, 1956</b> , that I last saw the deceased alive on <b>Nov 13, 1956</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clifford H. Byerly</b> M.D.				ADDRESS (Street, city or town, state) <b>3033 W. KAY ST.</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>M. Paul Byerly</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 16/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>A.A. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witzke</b>				ADDRESS <b>4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR <b>Nov 20 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>John H. Byerly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>altimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u>		c. LENGTH OF STAY IN 1b <u>37 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>	
3. NAME OF DECEASED (Type or print) First <u>ALLAN</u> Middle <u>T.</u> Last <u>TRICE</u>		4. DATE OF DEATH Month <u>November</u> Day <u>3</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/23/74</u>
9. AGE (In years last birthday) yrs. <u>32</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>	11. BIRTHPLACE (State or foreign country) <u>Seaford, Delaware</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Trice</u>	
14. MOTHER'S MAIDEN NAME <u>Rosie Williamson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Clin. Rec., Vet. Admin. Hosp., Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PERI CARDIAC MYOINFARCTION</u> <u>0211</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. p. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 26</u> , 19 <u>56</u> , to <u>November 3</u> , 19 <u>56</u> , that I last saw the deceased <u>alive on 11/3/56</u> and that death occurred at <u>5:00 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, Fort Howard, Md.</u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>C. J. Alastradt M.D.</u>			
PHYSICIAN'S NAME (Type) <u>C. J. ALASTRADT, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 6, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hindy Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Trappe, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carroll, Dutchman's Lane, Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov 7 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Douglas L. Barber</u>			

U.S. DEPT. OF JUSTICE

NOV 7 1956

RECEIVED



## 11155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>YORK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Delaney Valley Road</b>		d. STREET ADDRESS <b>Stewartstown RD #3</b>	
3. NAME OF DECEASED (Type or print) First <b>R.</b> Middle <b>EUGENE</b> Last <b>TROUT</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/20/35</b>
9a. AGE (In years last birthday) <b>20 yrs</b>		9b. IF UNDER 1 YEAR Months <b>27</b> Days <b>27</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hauling</b>	
11. BIRTHPLACE (State or foreign country) <b>East Hopewell Township, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Reed S. Trout</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Crull</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <b>204-28-3122</b>	
17. INFORMANT <b>Reed Trout Stewartstown Pa.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing injury of head</b> 819X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Sideswiped bridge and crashed into span</b>	
20c. TIME OF INJURY Month, Day, Year <b>11:30</b> <b>11/27</b> <b>1956</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20f. (City or town) (County) (State) <b>Baltimore, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R. S. Fisher</b>		DATE SIGNED <b>11/28/56</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-30-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Stewartstown</b>		22d. LOCATION (City, town, or county) (State) <b>Stewartstown York Co. Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth W. C. ...</b>		24a. REC'D BY REGISTRAR DATE <b>11/29/56</b>	
ADDRESS <b>Stewartstown Pa.</b>		24b. REGISTRAR'S SIGNATURE <b>Robert J. ...</b>	

THIS MEDICAL EXAMINER'S CERTIFICATE should be completed within 24 hours after death. If any delay is necessary, please advise the funeral home, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STANLEY A. S.

DEC

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

11155

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u>				c. LENGTH OF STAY IN 1b <u>ESSEX</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>38 CRAFTON RD.</u>				d. STREET ADDRESS <u>38 CRAFTON RD.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LOUISE</u> Last <u>ULRICH</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 16. 1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>MARGARET MENINGER</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Accident</u> DUE TO <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>Nov 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>56</u> , and that death occurred at <u>10:15</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert J. Lyden</u>		M.D. <u>815 Eastern Ave., Balt. 21, Md.</u>		ADDRESS (Street, city or town, state) <u>Balt. 21, Md.</u>		DATE SIGNED <u>Nov 2, 1956</u>	
PHYSICIAN'S NAME (Type) <u>R. J. LYDEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 5-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT CARMEL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Connelly</u>		ADDRESS <u>Essex 212d. 1</u>		24a. REC'D BY REGISTRAR <u>Edith Hurley</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## 11157 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER (2C)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at Home</u>		d. STREET ADDRESS <u>1212 4<sup>th</sup> Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>KARL A. VAN BIBBER</u>		4. DATE OF DEATH <u>11 - 19 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13 - 1898</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Met. Ins.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth-Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CLAUDE VAN BIBBER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-17-4715</u>	
17. INFORMANT <u>CEIL VAN BIBBER</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u> <u>411X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Rheumatoid cardio-valvular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u> <u>30 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>Nov 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 19</u> , 19 <u>56</u> , and that death occurred at <u>6:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Semenov</u>		ADDRESS (Street, city or town, state) <u>1437 Fendoga Ave</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>		DATE SIGNED <u>11/21/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-23-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Connolly - Exec. Md.</u>		ADDRESS <u>Baltimore 20, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 11-23-56</u>		24b. REGISTRAR'S SIGNATURE <u>Carth Hurley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUCKET A 3

10/21/2011

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11148

Reg. Dist. No.

11158

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2 mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Grove State Hospital</b>		e. STREET ADDRESS <b>601 Main Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Hortense</b> Middle <b>NMI</b> Last <b>Ward</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>24</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 29, 1876</b>
9. AGE (in years last birthday) <b>79</b> yrs		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>24</b> Hours <b>00</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Charles Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Coelistius Hayden</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Bailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral hemorrhage</b> DUE TO (c) <b>Hypertensive cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>4 days</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept. 12, 1956 - Nov. 24, 1956</b> , 19____, that I last saw the deceased alive on <b>Nov. 24, 1956</b> , 19____, and that death occurred at <b>2:45 P.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Charles Ward M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Charles Ward Spring Grove State Hosp. Catonsville 28, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/25/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington Laurel, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James T. Ryan, Jr. 317 P. Ave. S.E. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>WASH. 3</b>	24b. REGISTRAR'S SIGNATURE <b>F. E. Gary</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BOULEVARD V. S.

1914



## 11159 CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
c. LENGTH OF STAY IN TB <b>18 Yrs.</b>		d. STREET ADDRESS <b>1913 Oak Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1913 Oak Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>John</b> Last <b>Warns</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>9</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1907</b>
9. AGE (In years last birthday) <b>49</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Warns</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Hohman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-28-7328</b>	
17. INFORMANT <b>Eileen E. Warns</b>		Address <b>1913 Oak Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension with Cardiac Disease</b> DUE TO (c) <b>10 yrs</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10-9-56</b> to <b>10-9-56</b> , that I last saw the deceased alive on <b>10-9-56</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas G. Abbott</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>4509 Liberty Heights Ave. 11-11-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-12-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. Howard Strong</b>		24a. REC'D BY REGISTRAR <b>Dr. Jm. E. Martin</b>	

THE MARRIED OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURTON J. A. 2

JOV 12 1950

RECEIVED  
JAN 12 1950

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11151

11160

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Anna</b> Last <b>Webster</b>				4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>19 56</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC 16 1889</b>	
9. AGE (In years last birthday) <b>67 1/2</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Martin Jonas</b>		14. MOTHER'S MAIDEN NAME <b>Victoria</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Mrs. Johnston</b> Address <b>1437 Reynolds St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO Cardiovascular disease DUE TO Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 14, 19 56</b> , to <b>Nov. 26, 19 56</b> , that I last saw the deceased alive on <b>Nov. 26, 19 56</b> , and that death occurred at <b>6:45 a. m.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>11-26-56</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>11/28/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery Balto. Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles F. Miller</b>				24a. REC'D BY REGISTRAR <b>Nov 29 1956</b>		24b. REGISTRAR'S SIGNATURE <b>H. B. Henry</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11161 CERTIFICATE OF DEATH

11150 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>1511 NORTHERN PARKWAY</b>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>(NMI)</b> Last <b>WESTER</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>22</b> Year <b>19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 2, 1896</b>
9. AGE (In years last birthday) <b>60</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Purchasing Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electronic Business Newark, New Jersey</b>	
11. BIRTHPLACE (State or foreign country) <b>Newark, New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Wester</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Kiel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>156-05-078</b>	
17. INFORMANT <b>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF PROSTATE WITH GENERALIZED METASTASES</b> 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 4, 1956</u> to <u>November 22, 1956</u> and that death occurred at <u>7:00A M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>C. J. Papastrat MD.</u> M.D. <u>VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>11/23/56</u>	
PHYSICIAN'S NAME (Type) <u>C. J. PAPASTRAT, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-26-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u> ADDRESS <b>6009 Harford Rd., Balto., Md.</b>		24a. REC'D BY REGISTRAR <u>Wm. Cook-Blight, Inc.</u> 24b. REGISTRAR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 1, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU W. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 1  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3  
 TO FURNITURE: This certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11152

## CERTIFICATE OF DEATH

Reg. Dist. No.

30

11162

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>4 months</b>				d. STREET ADDRESS <b>3834 Elmley Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home-329 Harlem Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AUGUSTA</b> Middle <b>ELIZABETH</b> Last <b>WHITE</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>28,</b> Year <b>19 56</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Approx. 76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Eldridge Windsor</b>				14. MOTHER'S MAIDEN NAME <b>Mary Webster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. E. Gerald White - 3834 Elmley Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema right</b> <b>4-2-2-2</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Pulmonary embolism</b> DUE TO (c) <b>Myocarditis chronic</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>I day</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <b>Myocardial hypertrophy. 5 yrs.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no injury</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no injury</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>no injury</b>		20f. (City or town) (County) (State) <b>no injury</b>	
21. I certify that I attended the deceased from <b>Dec 6th</b> , 19 <b>55</b> , to <b>Nov 28</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>November 28</b> , 19 <b>56</b> , and that death occurred at <b>4.30 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>516 Cathedral Street Balto I Md</b>				DATE SIGNED			
ACTUAL SIGNATURE <b>James G. Marston</b>		M.D. <b>516 Cathedral Street Balto I Md</b>					
PHYSICIAN'S NAME (Type) <b>James Graham Marston, M.D.</b>		ADDRESS <b>516 Cathedral Street Balto I Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/1/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto</b>				24a. REC'D BY REGISTRAR <b>DEC 3 1956</b>		24b. REGISTRAR'S SIGNATURE <b>J. E. Lany</b>	

BUREAU V. S.

NO. 1

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11153 *28*

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>220 Hopkins Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson (Rodgers Forge)</b> d. STREET ADDRESS <b>220 Hopkins Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <b>VIOLET</b> (Frances) Last <b>WHITE</b>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>19</b> Year <b>1956</b>		<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 19, 1898</b>		<b>9. AGE</b> (In years last birthday) <b>58</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>homemaker</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>at home</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Penna.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b>					
<b>13. FATHER'S NAME</b> <b>Wm. M. Jones</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Laura B. -</b>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>no</b>		<b>17. INFORMANT</b> Address <b>Mrs. Marion Roettger - 1352 Winston Ave.</b>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hanging</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)														INTERVAL BETWEEN ONSET AND DEATH			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <b>Hanged self</b>													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b>				<b>20f. (City or town)</b> <b>Towson</b>				(County) <b>Baltimore</b>		(State) <b>Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
<div style="display: flex; justify-content: space-between;"> <div> <b>EXAMINER'S NAME (Type)</b>  <b>Paul F. Guerin, M.D.</b> </div> <div> <b>DATE SIGNED</b>  <b>11/19/56</b> </div> </div>																	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b>				<b>22b. DATE THEREOF</b> <b>11/21/56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park Cem.</b>				<b>22d. LOCATION (City, town, or county)</b> <b>Balto., Md.</b>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Wm. J. Tichenor &amp; Sons - Balto 17 Md</i>																	
<b>24a. RECEIVED BY REGISTRAR</b> DATE <b>Nov. 20, 1956</b>								<b>24b. REGISTRAR'S SIGNATURE</b> <i>Malcolm Gray</i>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar to burial or cremation, or removal.

1000

1000

1000

## 11164 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>				c. LENGTH OF STAY IN 1b <b>74 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>2734 W. Lafayette Street</b>			
3. NAME OF DECEASED (Type or print) First <b>MELVIN</b> Middle <b>R.</b> Last <b>WILLIAMS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/23/20</b>	
9. AGE (In years last birthday) <b>36</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Boring, Md.</b>	
13. FATHER'S NAME <b>John Williams</b>				14. MOTHER'S MAIDEN NAME <b>Margaret E. Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WW II</b>				16. SOCIAL SECURITY NO <b>219-12-7842</b>		17. INFORMANT Address <b>Clin. Rec. Folder, Vet. Adm. Hosp., Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE DUE TO PNEUMONITIS</b> DUE TO (b) <b>CARCINOMA OF STOMACH</b> DUE TO (c) <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNKNOWN</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>August 21, 1956</b> , to <b>November 3, 1956</b> , and that death occurred at <b>7:00 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter H. Levy</b>				ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MD.</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>WALTER H. LEVY, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 7, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Katie Williams</b>				24a. REC'D BY REGISTRAR <b>Nov 7 1956</b>		24b. REGISTRAR'S SIGNATURE <b>James L. Harvey</b>	
Katie Williams Funeral Home, 322 N. Schroeder Balto., Md.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A. 1956

1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film 207 11-20-55 et

## CERTIFICATE OF DEATH

11155  
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Reg. Dist. No.

11165

Item 2 Film 207 11-20-55 et

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto. 29</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry Winter</b>		4. DATE OF DEATH <b>Nov. 4, 1956</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith, Crown Cork &amp; Seal Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Md.</b>	
13. FATHER'S NAME <b>Francis Winter</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>705-03-94864</b>	
17. INFORMANT <b>Mrs Naomi F. McQuaid</b>		Address <b>322 Allendale St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma tongue with cerebral metastases</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>9 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-8</b> , 1955, to <b>Nov. 4</b> , 1956, that I last saw the deceased alive on <b>11-4</b> , 1956, and that death occurred at <b>11:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John F. Schaefer</b> M.D.		ADDRESS (Street, city or town, state) <b>401 Random Road Balto. 29 Md.</b>	
PHYSICIAN'S NAME (Type) <b>JOHN F. SCHAEFER</b>		DATE SIGNED <b>Nov. 13, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 7/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Wipke</b>		24a. REC'D. BY REGISTRAR <b>DATE</b>	
ADDRESS <b>4101 Edmondson Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>H. E. Hays</b>	

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11156

## CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>233 Pinewood Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ottile</b> Middle <b>P.</b> Last <b>Winters</b>		4. DATE OF DEATH Month <b>11</b> Day <b>16</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1874</b>
9. AGE (In years last birthday) <b>82</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <b>Germany</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Carl Siebert</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Schmidt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Carl Sipes, 233 Pinewood Avenue</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Hypertensive Cardio-Vas. Disease</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Arteritis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1953</b> to <b>16 Nov. 56</b> , that I last saw the deceased alive on <b>15 Nov. 1956</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Dundalk, Md.</b> DATE SIGNED <b>22 Nov.</b>			
ACTUAL SIGNATURE <b>W. H. Morrison</b>		M.D. <b>Dundalk, Md.</b>	
PHYSICIAN'S NAME (Type) <b>W. H. Morrison</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-19-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mathews</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. RECEIVED BY REGISTRAR DATE <b>Nov. 19, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>Wm. Kelly</b>

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## 10990 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b> Md. </b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4200 Maryland Place</b>		d. STREET ADDRESS <b>4200 Maryland Place</b>	
3. NAME OF DECEASED (Type or print) <b>Alwin Wode</b>		4. DATE OF DEATH Month <b>11-17-56</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 7, 1878</b>
9. AGE (In years last birthday) <b>78</b> yrs		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (State or foreign country) <b>Hanover Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>William Wode</b>		14. MOTHER'S MAIDEN NAME <b>Leana</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b> (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Marie E. Wode, 4203 Maryland Place</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis, left with right hemiplegia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>10 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 6, 1956</b> , to <b>Nov. 16, 1956</b> , that I last saw the deceased alive on <b>Nov. 16, 1956</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert J. Leickow</b>		ADDRESS (Street, city or town, state) <b>5305 East Drive Baltimore -27 Md</b> DATE SIGNED <b>11/17/56</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-20-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Pauls</b>		22d. LOCATION (City, town, or county) (State) <b>Violetville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard W. Hubbard, 4107 Wilkens Ave</b>		24a. REC'D BY REGISTRAR DATE <b>11-21-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Dr. Geo. Pfeiffer</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## 32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McDonogh, Md</u>		c. LENGTH OF STAY IN lb <u>10 minutes</u> <u>Baltimore 18,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1147 Gorman Ave</u>	
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mamie Belle Working</u>		4. DATE OF DEATH Month Day Year <u>Nov 10 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27, 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles McDonald</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Shipley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Richard Working, McDonogh, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 Nov 56</u> to <u>10 Nov 56</u> that I last saw the deceased alive on <u>Dead on arrival</u> and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above. <u>Deceased under Dr. Wm. Hammerlin care for heart disease.</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>Paul H Royse M.D. 808 Reisterstown Rd 10 Nov 56</u> PHYSICIAN'S NAME (Type) <u>Paul H Royse MD</u> <u>Pikesville 8 Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-14-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>Nov 14 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Dorothy J. Smith</u>			

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BUREAU V. E.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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11167

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>1hr.1/2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Garrison Forrest Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henrietta</u> Middle <u>Park</u> Last <u>Xanders</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1892</u>		9. AGE (In years last birthday) <u>64</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henery Ingman Park</u>				14. MOTHER'S MAIDEN NAME <u>Lelle Chapman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harold L. Xanders, Garrison, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Skull &amp; Left Clavicle &amp; Ribs</u> INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> DUE TO (b) <u>Fall down cellar steps</u> <u>1/2 hr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF DEATH <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down cellar steps</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> a. m. <u>Nov. 22</u> 19 <u>56</u> b. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) <u>Friends home</u>		20f. (City or town) (County) (State) <u>Reisterstown, Balto., Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D.D. Caples</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D.D. Caples, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 24 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garrison, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville</u>				24a. REC'D BY REGISTRAR <u>Nov 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Anthony Newell</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WILLIAM A. HARRIS

1906

NOV

WILLIAM A. HARRIS

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11168 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11160** *44*

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>		c. LENGTH OF STAY IN lb <b>30 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ft. Howard Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b>	
f. STREET ADDRESS <b>537 Moore St.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>W.</b> Last <b>YARBROUGH</b>		4. DATE OF DEATH Month <b>NOV</b> Day <b>2</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec 29, 1896</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pittsboro N.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsboro N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Cornelia ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>231-07-6250</b>	
17. INFORMANT <b>Gladis Bullock</b>		Address <b>517 W. Biddle St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>445X HYPERTENSIVE CARDIOVASCULAR DISEASE</b>  Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.  <b>DUE TO PULMONARY THROMBOSIS</b></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b></b></p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour <b></b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>PAUL F. GUERIN</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 8, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Holstead</b>		ADDRESS <b>918 Druid Hill Ave</b>	
24a. REC'D BY REGISTRAR <b>Nov. 5, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Fisker</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registrars prior to burial, cremation, or removal.

BUREAU V. S.

NOV 2 1956

7-1-56



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>519 Middle River Road</u>		d. STREET ADDRESS <u>519 Middle River Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Yeager</u>		4. DATE OF DEATH Month Day Year <u>Nov. 14 1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Hanna</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <u>Mr. Alberr F. Yeager, Sr. 519 Middle River</u>	
16. SOCIAL SECURITY NO.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Arteriosclerotic Cardiovascular disease</u> (c) <u>2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 5, 1956</u> to <u>Nov 14, 1956</u> that I last saw the deceased alive on <u>Nov 14, 1956</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Baumgardner</u> M.D.		ADDRESS (Street, city or town, state) <u>Balto 6 Md</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>11/14/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/17/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Edith Harby</u>

BUREAU V. S.

NOV 19 1952

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11162

## 11170 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>75 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MOSES</b> Middle <b>H.</b> Last <b>YORK</b>				4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/28/89</b>	
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		11. BIRTHPLACE (State or foreign country) <b>Harrisonburg, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Wesley York</b>				14. MOTHER'S MAIDEN NAME <b>Phyllis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>213-01-0579</b>		17. INFORMANT <b>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF PANCREAS WITH METASTASIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> 19 <b>56</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>August 30</b> , 19 <b>56</b> , to <b>November 13</b> , 19 <b>56</b> , and that death occurred at <b>5:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>WALTER J. PIJANOWSKI, M. D.</b> <b>VAH, Fort Howard, Maryland</b> <b>11/13/56</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/16/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>William A. Jackson, Inc., 916 Pa. Ave., Balto., Md.</b>				24a. REC'D BY REGISTRAR <b>19 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Larkins</b>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Birth		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Residence		Place of Birth		Date of Arrival	
Signature of Physician		Signature of Registrar		Signature of Informant	

BUREAU Y. 2

NOV 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11163

## 10991 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1026 Leeds Avenue</b>				d. STREET ADDRESS <b>1026 Leeds Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>M. Sinnell</b> Last <b>Sinnell</b>				4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1885</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	IF UNDER 24 HRS. Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Hyland Pennington</b>				14. MOTHER'S MAIDEN NAME <b>Ann R. Reiter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Mr. William Sinnell 1026 Leeds Avenue</b>			
17. INFORMANT <b>Mr. William Sinnell 1026 Leeds Avenue</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A. S. C. V. D.</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3/9</b> , 19 <b>55</b> , to <b>11/19</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11/18/56</b> , 19 <b>56</b> , and that death occurred at <b>12:05</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John C. Kelly</b> M.D.				ADDRESS (Street, city or town, state) <b>Baltimore, Md</b> DATE SIGNED <b>11/19/56</b>			
PHYSICIAN'S NAME (Type) <b>John C. Kelly</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/23/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Avenue</b>				24a. REC'D BY REGISTRAR <b>DATE 11-21-56</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. J. S. Kieffer</b>	

CERTIFICATE OF DEATH

BUREAU V. 2

21 31 1956

RECEIVED